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In The

Supreme Court of the United States

October Term, 1997

BEVERLY COMMUNITY HOSPITAL ASSOCIATION, a California non-profit public benefit corporation, d/b/a BEVERLY HOSPITAL, *et al.*,

Petitioners,

vs.

S. KIMBERLY BELSHÉ, Director of the California Department of Health Services,

Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

This case addresses the extent of the obligation of state Medicaid programs to pay the Medicare deductibles and co-insurance ("cost-sharing") for certain low-income Medicare beneficiaries who are designated as Qualified Medicare Beneficiaries. The precise questions presented to the Court are as follows:

A. Whether the United States Courts of Appeals for the Ninth Circuit erred in ignoring four other Courts of Appeals decisions holding that 42 U.S.C. §§ 1396a(a)(10)(E) and 1396d(p)(3) clearly require states to pay full Medicare cost-sharing for Qualified Medicare Beneficiaries, by deferring to Section 4714 of the Balanced Budget Act of 1997, so-called "clarifying" legislation enacted by Congress more than 10 years after the statutes in question were enacted, and after the services in question were rendered by health care providers?

B. Whether the Separation of Powers Doctrine, based in this case on Article III of the United States Constitution, prohibits Congress from directing the outcome of this case and other pending litigation in a manner beneficial to the government, by the retroactive application of Section 4714(a) of the Balanced Budget Act of 1997 only to such litigants?

C. Whether the retroactive application of Section 4714 of the Balanced Budget Act of 1997 to payment for health care services already provided impairs vested property rights protected by the Just Compensation Clause of the Fifth Amendment to the United States Constitution?

PARTIES TO THE PROCEEDINGS

Parties to this proceeding are all hospitals providing inpatient hospital services to California residents who are Qualified Medicare Beneficiaries not listed in the caption ("QMBs"). The named representative hospitals not listed in the caption are:

BELLWOOD MEDICAL CORPORATION, d/b/a BELLWOOD GENERAL HOSPITAL; CHICO COMMUNITY HOSPITAL MEDICAL CENTER, INC., d/b/a CHICO COMMUNITY REHABILITATION HOSPITAL, d/b/a CHICO COMMUNITY HOSPITAL; HOLLYWOOD COMMUNITY HOSPITAL MEDICAL CENTER, INC., d/b/a HOLLYWOOD COMMUNITY HOSPITAL OF VAN NUYS, d/b/a HOLLYWOOD COMMUNITY HOSPITAL OF HOLLYWOOD; LANCASTER HOSPITAL CORPORATION, d/b/a LANCASTER COMMUNITY HOSPITAL, LINCOLN COMMUNITY MEDICAL CORPORATION, d/b/a Orange County Community Hospital of Orange; MONROVIA HOSPITAL CORPORATION, d/b/a Monrovia Community Hospital; PARACELSUS LOS ANGELES COMMUNITY HOSPITAL, INC., d/b/a Los Angeles Community Hospital of Los Angeles and Los Angeles Community Hospital of Norwalk; MISSION HOSPITAL REGIONAL MEDICAL CENTER, a California non-profit corporation; QUEEN OF THE VALLEY HOSPITAL OF NAPA, CALIFORNIA, a California non-profit corporation; REDWOOD MEMORIAL HOSPITAL OF FORTUNA, a California non-profit corporation; ST. JOSEPH HOSPITAL OF EUREKA, a California non-profit corporation; ST. JOSEPH HOSPITAL OF ORANGE, a California non-profit corporation; ST. JUDE HOSPITAL, INC., a California non-profit corporation, d/b/a St. Jude Medical Center; ST. MARY DESERT VALLEY HOSPITAL, a California non-profit corporation; SANTA ROSA MEMORIAL HOSPITAL, a California non-profit corporation; NME HOSPITALS, INC.,

d/b/a Doctors Hospital of Montero, Community Hospital and Rehabilitation Center of Los Gatos, Redding Medical Center, Garfield Medical Center, Doctors Medical Center, Modesto, Doctors Hospital of Pinole, John F. Kennedy Memorial Hospital, Los Alamitos Medical Center, Century City Hospital, Lakewood Regional Medical Center, Alvarado Medical Center, Placentia Circle Community Hospital, Twin Cities Community Hospital, San Ramon Regional Medical Center, and USC University Hospital; REHABILITATION FACILITY AT SAN RAMON, INC., a California corporation, d/b/a Golden State Rehabilitation Hospital; R.H.S.C. MODESTO, INC., a California corporation, d/b/a Rehabilitation Hospital of Modesto; NATIONAL MEDICAL SPECIALTY HOSPITAL OF REDDING, a California corporation, d/b/a Redding Specialty Hospital; REHABILITATION FACILITY AT SAN DIEGO, INC., a California corporation, d/b/a San Diego Rehabilitation Institute at Alvarado; MEDICAL CENTER OF GARDEN GROVE, INC., d/b/a Garden Grove Hospital; SAN DIMAS COMMUNITY HOSPITAL, INC., d/b/a San Dimas Community Hospital; AMISUB (Sierra Vista), INC., d/b/a Sierra Vista Regional Medical Center; NEW H SOUTH BAY, INC., d/b/a South Bay Community Hospital; AMI/HTI TARZANA ENCINO JOINT VENTURE, d/b/a Tarzana Regional Medical Center and Encino Hospital; AMISUB OF CALIFORNIA, INC., d/b/a Valley Doctors Hospital a/k/a Medical Center of North Hollywood; AMISUB (IRVINE MEDICAL CENTER, INC.), d/b/a Irvine Medical Center; CHINO COMMUNITY HOSPITAL CORPORATION, INC., d/b/a Chino Community Hospital; HUNTINGTON INTERCOMMUNITY HOSPITAL, d/b/a Huntington Beach Medical Center, f/k/a HH-Huntington Beach; LAS ENCINAS HOSPITAL, d/b/a Las Encinas Hospital; LOS ROBLES REGIONAL MEDICAL CENTER, d/b/a Los Robles Regional Medical Center; SLCO, INC., d/b/a San Leandro Hospital, f/k/a HH-San Leandro; WEST ANAHEIM COMMUNITY HOSPITAL, d/b/a West Anaheim Medical

Center, f/k/a HH-West Anaheim; WEST HILLS HOSPITAL, d/b/a West Hills Regional Medical Center, f/k/a HH-West Hills; HEALDSBURG GENERAL HOSPITAL, INC., d/b/a Healdsburg General Hospital; WEST LOS ANGELES PHYSICIANS HOSPITAL, INC., d/b/a Westside Hospital; MISSION BAY MEMORIAL HOSPITAL, INC., d/b/a Mission Bay Memorial Hospital; SEBASTOPOL HOSPITAL CORPORATION, d/b/a Palm Drive Hospital; ON BEHALF OF THEMSELVES AND ALL SIMILARLY SITUATED HOSPITALS.

STATEMENT PURSUANT TO RULE 29.6

As to named class members, information regarding parents or non wholly owned subsidiaries is as follows:

A. Paracelsus Healthcare Corporation is a publicly traded company and has an ownership interest in the following subsidiary corporations which are members of the class: Bellwood Medical Corporation, Chico Community Hospital Medical Center, Inc., Hollywood Community Hospital Medical Center, Inc., Lancaster Hospital Corporation, Lincoln Community Medical Corporation, Monrovia Hospital Corporation, and Paraceleus Los Angeles Community Hospital, Inc.

B. Tenet Healthcare Corporation, Inc. is a publicly traded company whose subsidiary corporation, NME Hospitals, Inc., is a named plaintiff that does business under the following hospital names: Doctors Hospital of Montero, Community Hospital and Rehabilitation Center of Los Gatos, Redding Medical Center, Garfield Medical Center, Doctors Medical Center, Modesto, Doctors Hospital of Pinole, John F. Kennedy Memorial Hospital, Los Alamitos Medical Center, Century City Hospital, Lakewood Regional Medical Center, Alvarado Medical Center, Placentia Circle Community Hospital, Twin Cities Community Hospital, San Ramon Regional Medical Center, and USC University Hospital. Additionally, Tenet Healthcare Corporation, Inc. is the parent company of The Rehabilitation Facility at San Ramon, Inc., RHSC Modesto, Inc., National Medical Specialty Hospital of Redding, Rehabilitation Facility at San Diego, Inc., Medical Center of Garden Grove, Inc., San Dimas Community Hospital, Inc., AMISUB, Inc., New H South Bay, Inc., AMI\HTI Tarzana-Encino Joint Venture, AMISUB of California, Inc., AMISUB (Irvine Medical Center, Inc.).

C. Columbia\HCA Healthcare Corporation, a publicly traded corporation, is the parent or affiliate of the following corporations which are listed as representative members of the class: Chino Community Hospital Corporation, Inc., Huntington Intercommunity Hospital, Las Encinas Hospital, Los Robles Regional Medical Center, SLCO, Inc., West Anaheim Community Hospital, West Hills Hospital, Healdsburg General Hospital, Inc., West Los Angeles Physicians Hospital, Inc., Mission Bay Memorial Hospital, Inc., Sebastopol Hospital Corporation.

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Beverly Community Hospital Association, *et al.*, (collectively "Hospitals" or "Petitioners") on behalf of a class consisting of similarly situated hospitals, respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Ninth Circuit in favor of respondent, S. Kimberly Belshé, as Director of the California Department of Health Services ("California").

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Ninth Circuit (App. A) is reported at 132 F.3d 1259 (9th Cir. 1997). The judgment of the United States District Court for the Central District of California (App. B) and its subsequent order (App. C) are also unreported. The denial of rehearing and the denial of the suggestion for rehearing *en banc* (App. D) are unreported.

STATEMENT OF JURISDICTION

The Court of Appeals entered its judgment on December 2, 1997. (App. A). A petition for rehearing and suggestion for rehearing *en banc* (App. D) was rejected on March 3, 1998. (App. D). Congress granted the Court jurisdiction over such final judgments by writ of certiorari pursuant to 28 U.S.C. § 1254(1). Because 28 U.S.C. § 2403(a) may apply, pursuant to Rule 29.4(b), Petitioners are concurrently serving the Solicitor General of the United States with this Petition.

CONSTITUTIONAL PROVISIONS AND STATUTES INVOLVED

The following Constitutional provisions are involved in this case: Article III, and the Just Compensation Clause of the Fifth Amendment. The following statutes are involved in this case: 42 U.S.C. §§ 1396a(a)(10)(E)(i), 1396a(n), and 1396d(p)(3). The Balanced Budget Act of 1997, Pub. L. 105-33, § 4714, 111 Stat. 251, 509-10 (1997) is also involved in this case.

STATEMENT OF THE CASE

This case addresses the extent of state Medicaid agency obligations under the Social Security Act to pay the Medicare deductibles and co-insurance ("cost-sharing") for certain low income persons known as Qualified Medicare Beneficiaries ("QMBs"). QMBs, who may be eligible for the full scope of Medicaid benefits or only Medicare cost-sharing payments, are "bought in" to the Medicare program by state Medicaid payment of their premiums.

In June 1995, a class, consisting of all hospitals that provide inpatient services to California's QMBs (the "Hospitals"), filed suit in the United States District Court for the Central District of California challenging California's refusal to pay, through its Medi-Cal program,[1] any of the Medicare cost-sharing associated with inpatient hospital services provided to QMBs.[2] Medi-Cal's refusal to make the cost-sharing payments to hospitals for their inpatient services represented an annual reduction of approximately $130 million in payments to hospitals, which are prohibited under federal and state law from turning to the QMBs for payment of the Medicare cost-sharing.

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1. "Medi-Cal" is California's version of Medicaid, which is a cooperative federal-state program established to provide medical care to low-income individuals and families. 42 U.S.C. § 1396 *et seq.* (1995); Cal. Welf. & Inst. Code § 14000 *et seq.* (1996).

2. That policy, effective May 1, 1994, is similar to Medi-Cal's refusal to pay full Medicare cost-sharing for physician services and ambulance services, which is the subject of the companion cases heard by the Ninth Circuit at the same time as this case, *California Ambulance Ass'n v. Shalala* ("CAA"), *California Medical Ass'n v. Shalala* ("*CMA*"), and *Gilmore v. Shalala* ("*Gilmore*") (the "Related Cases"). One opinion was issued by the Ninth Circuit for the related cases and this case. 132 F.3d 1259. Petitions for Certiorari are being filed concurrently with this case in the *CAA* and *CMA* cases (which are consolidated) and in the *Gilmore* case.

The Hospitals relied on two provisions of the Social Security Act to support their claim to full cost-sharing payments from Medi-Cal: 42 U.S.C. § 1396a(a)(10)(E)(i), which requires state Medicaid programs to pay Medicare cost-sharing for QMBs, and 42 U.S.C. § 1396d(p)(3), which defines Medicare cost-sharing to include premiums, deductibles and coinsurance, without any limitation. Four United States Courts of Appeals had held already that those provisions clearly required state Medicaid programs to make full cost-sharing payments. *Rehabilitation Ass'n of Virginia v. Kozlowski*, 42 F.3d 1444 (4th Cir. 1994), *cert. denied*, 516 U.S 811, 116 S. Ct. 60, 133 L. Ed. 2d 23 (1995) ("*Kozlowski*"); *Haynes Ambulance Serv., Inc. v. State of Alabama*, 36 F.3d 1074 (11th Cir. 1994) ("*Haynes*"); *Pennsylvania Medical Society v. Snider*, 29 F.3d 886 (3d Cir. 1994) ("*Snider*"); *New York City Health and Hosps. Corp. v. Perales*, 954 F.2d 854 (2d Cir. 1992), *cert. denied*, 506 U.S. 972, 113 S. Ct. 461, 121 L. Ed. 2d 369 (1992) ("*Perales*") (hereinafter referred to in the aggregate as the "Four Circuits").

The District Court below, Judge Spencer Letts, following the opinions of the Four Circuits, granted summary judgment and a permanent injunction in favor of the Hospitals effective December 11, 1995, requiring Medi-Cal to make the full Medicare cost-sharing payments associated with hospital inpatient services. Defendant S. Kimberly Belshé, Director of the California Department of Health Services, the State Medi-Cal agency, complied with the injunction, but appealed the decision to the Ninth Circuit. The State subsequently appealed decisions by the same District Court judge in the cases pertaining to the Related Cases; those appeals were considered concurrently with this case.

Prior to oral argument before the Ninth Circuit, Congress enacted Section 4714 of the Balanced Budget Act of 1997 ("BBA"), Pub. L. No. 105-33 (App. E), which became effective on August 5, 1997. Section 4714 provides that state Medicaid agencies are

not required to pay Medicare cost-sharing for QMBs to the extent that such a payment would exceed what would otherwise be paid under the State Medicaid plan for the same item or service if provided to an eligible Medicaid recipient who is not a Medicare beneficiary. (*See* App. E). The parties do not dispute that from the date of enactment, August 5, 1997, states may limit the payment of cost-sharing for QMBs to the level of their Medicaid rates, even if the full Medicare payment for the service would be higher.

In addition to making Section 4714(a) effective for items and services provided on or after August 5, 1997, Congress stated in Section 4714(c) that the amendments affecting the states' cost-sharing obligation shall apply to payments for preenactment services, but only if such payments are the subject of a lawsuit pending as of, or initiated after, that date. Thus, shortly before this matter reached the Ninth Circuit, the legal landscape had changed. The Ninth Circuit appeared obliged not only to consider the original state of the law, but also the possible impact of Section 4714 on the state of the law prior to its enactment.

The Ninth Circuit issued its decision on December 2, 1997, writing a single opinion for this and the Related Cases. *Beverly Community Hosp. Ass'n v. Belshé*, 132 F.3d 1259 (9th Cir. 1997). "Eschewing any analysis" of the parties' arguments regarding the pre-BBA state of the law, and relying on its belief that clarity is generally absent from the Medicare and Medicaid statutes as a whole, the Ninth Circuit held that the pre-BBA law was ambiguous and that Section 4714 is a clarification of what the law always meant. 132 F.3d at 1264, 1266-67. Accepting the "clarification" as a statement of existing law, the court rejected without consideration the Hospitals' claims that the retroactive application of Section 4714 solely to payment for preenactment services subject to litigation violates separation of powers principles founded in Article III of the United States Constitution, and represents an unlawful taking under the Just Compensation Clause of the Fifth

Amendment. Based on the Ninth Circuit's decision, California now has the authority to recoup hundreds of millions of dollars which were paid to hospitals pursuant to the District Court's injunction.

On March 3, 1998, the Ninth Circuit denied the Hospitals' petition for rehearing and suggestion for rehearing *en banc*.

REASONS FOR GRANTING THE WRIT

I. IN FINDING THAT DEFERENCE SHOULD BE GIVEN TO SECTION 4714 OF THE BALANCED BUDGET ACT OF 1997 BECAUSE EARLIER ENACTMENTS WERE UNCLEAR, THE DECISION BELOW, AND THE SEVENTH CIRCUIT'S DECISION IN *PARAMOUNT HEALTH SYSTEMS, INC. v. WRIGHT*, CONFLICT WITH DECISIONS OF THE SECOND, THIRD, FOURTH AND ELEVENTH CIRCUITS HOLDING THAT 42 U.S.C. § 1396a(a)(10)(E)(i) AND 42 U.S.C. § 1396d(p)(3) UNAMBIGUOUSLY REQUIRE STATES TO PAY FULL MEDICARE COST-SHARING FOR QUALIFIED MEDICARE BENEFICIARIES. THE PETITION SHOULD BE GRANTED TO RESOLVE THAT CONFLICT, AS WELL AS TWO CONFLICTING LINES OF SUPREME COURT CASES REGARDING THE DEGREE OF DEFERENCE TO BE GIVEN TO LEGISLATION WHICH PURPORTS TO INTERPRET EARLIER CONGRESSIONAL ENACTMENTS.

Both the Ninth Circuit and the Seventh Circuit reversed lower court decisions favorable to healthcare providers by deferring to Section 4714 as a clarification of longstanding Social Security Act provisions relating to state Medicaid payment obligations for QMB cost-sharing.[3] The Ninth Circuit indicated that it would have

3. *Beverly*, 132 F.3d 1259; *Paramount Health Systems v. Wright*, 138 F.3d 706 (7th Cir. 1998) ("*Paramount*"). It is the Hospitals' understanding (Cont'd)

considered the Hospital's constitutional arguments criticizing the application of Section 4714 to preenactment services if it had found the prior law clear. 132 F.3d at 1265. The Seventh Circuit went further, suggesting that it might have *accepted* the providers' constitutional arguments if it had not found the statutory scheme ambiguous and if it was not obliged, under certain Supreme Court precedent, to defer to Congress' "clarification." *Paramount*, 138 F.3d at 710. In finding statutory ambiguity, the Ninth and Seventh Circuit decisions directly conflict with the earlier decisions of the Four Circuits — the Second, Third, Fourth and Eleventh — which, without the influence of Congress' recent intervention, held that the Social Security Act *unambiguously* required states to pay full Medicare cost-sharing for QMBs.

In deferring to Section 4714 as a clarification of prior law, the court below relied on *Loving v. United States*, 517 U.S. 748, 770, 116 S. Ct. 1737, 1749, 135 L. Ed. 2d 36 (1996) and other decisions of this Court which have accorded great weight to legislation said to express the intent of an earlier statute. 132 F.3d at 1265. The *Paramount* decision, however, noted that there is a contrary line of decisions by this Court, exemplified by *United States v. Philadelphia National Bank*, 374 U.S. 321, 348-49, 83 S. Ct. 1715, 1733, 10 L. Ed. 2d 915 (1963), and most recently reaffirmed in *South Dakota v. Yankton Sioux Tribe*, 118 S. Ct. 789, 139 L. Ed. 2d 773 (1998), wherein the Court stated that the "views of a subsequent Congress form a hazardous basis for inferring the intent of an earlier one."[4] While feeling constrained to follow the

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(Cont'd)
that the providers in *Paramount* intend to file a petition for writ of certiorari within the next few weeks.

4. *See also United States v. Estate of Francis J. Romani*, 118 S. Ct. 1478, 1479, 66 U.S.L.W. 4295, 4300 (1998) ("The Constitution puts Congress in the business of writing new laws, not interpreting old ones. '[L]ater enacted laws . . . do not declare the meaning of earlier law.' " (Scalia, J. concurring)).

Loving line of cases, Judge Posner in *Paramount* invited the Court to definitively resolve the conflict between these two divergent lines of cases. 138 F.3d at 710-11.

A. There is Conflict Among the Circuits Regarding the Clarity of Prior Law.

The Four Circuits analyzed the statutes under the familiar principles of *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 104 S. Ct. 2778, 81 L. Ed. 2d 694 (1984). Under *Chevron*, courts only defer to an agency interpretation of a statute if Congressional intent is not clear. All Four Circuits, in lengthy and considered opinions, held that the statutory language and contemporaneous legislative history indicated unambiguous Congressional intent, and thus never reached the second step of *Chevron*.

The court below essentially abdicated its judicial responsibilities by skipping over the first step of *Chevron* entirely. In fact, the court baldly stated that it was "eschew[ing] any analysis" of the meaning and history of the statutes at issue, because of Congress' intervening "clarification." 132 F.3d at 1264. Astonishingly, the court does not even cite the two statutes which are the foundation of the Hospitals' argument and the basis for the decisions of the Four Circuits: 42 U.S.C. §§ 1396a(a)(10)(E)(i) and 1396d(p)(3).[5] Similarly, the Seventh Circuit, while making more of an effort than the Ninth Circuit to actually look at the pre-BBA state of the law, premised its conclusion that the statutes were ambiguous on an incomplete and inaccurate analysis.

The mandatory payment obligation on behalf of QMBs is found at Section 1396a(a)(10)(E)(i):

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5. The court's statement, later in its opinion, that it made an effort "to parse the intricate and complex provisions of the pre-Act legislation" is unconvincing, as none of this analysis appears in the opinion. 132 F.3d at 1266-67.

> [The state Medicaid plan must provide] for making medical assistance available for medicare cost-sharing (as defined in section 1396d(p)(3) of this title) for qualified medicare beneficiaries described in section 1396d(p)(1) of this title. . . .

42 U.S.C. § 1396a(a)(10)(E)(i) (App. E). Section 1396d(p)(3) defines Medicare cost-sharing to include premiums, coinsurance and deductibles. 42 U.S.C. § 1396d(p)(3) (App. E). Neither the requirement that states pay the Medicare cost-sharing nor the definition of the cost-sharing which must be paid includes any qualifications whatsoever.

These statutes were first enacted in 1986.[6] Legislative history

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6. The history and development of the relevant statutes is somewhat lengthy and has been discussed in great detail in the opinions issued by the Four Circuits. *See, e.g., Kozlowski*, 42 F.3d at 1450-58. Essentially, prior to 1986, states, for almost 20 years, were required to make Medicare cost-sharing payments for "dual eligibles," those persons who were eligible for benefits under both the Medicare and state Medicaid programs. The basis for this obligation was 42 U.S.C. § 1396a(a)(15) (repealed 1988), which provided for full cost-sharing except for a charge which the state could make to the beneficiaries themselves based on their income and resources. In 1986, Congress established a new category of Medicare beneficiary, the QMBs, who were not quite poor enough to meet Medicaid eligibility requirements, but for whom states could "buy in" to the Medicare program by paying their Medicare premiums, deductibles and co-insurance. Aside from these items, the QMBs (sometimes referred to as "pure QMBs") did not receive regular Medicaid benefits. Sections 1396a(a)(10)(E)(i) and 1396d(p)(3) set forth the states' obligation to pay the cost-sharing for QMBs, which was a state option in 1986 and became mandatory in 1988. Likewise, in 1988, the "dual eligibles" were merged into the definition of QMBs, which since then has covered all Medicare beneficiaries who are poor enough to meet the QMB income and resource guidelines, regardless of whether they meet the Medicaid guidelines as well. Thus, since 1988, Sections 1396a(a)(10)(E)(i) and 1396d(p)(3) have controlled the states' cost-sharing obligation for dual

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contemporaneous with the enactment of these statutes is consistent with the clear language of the statutes and fully supports the Hospitals' position that the states' cost-sharing obligation is mandatory and unqualified.[7] This is consistent with Congress's goal to expand medical coverage for persons under the poverty line by allowing, and later mandating, states to buy these persons into the Medicare program, without extending full Medicaid coverage to these persons, which would have been much more

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eligibles and "pure" QMBs alike. In 1988, Congress also removed the provision which allowed states to charge dual eligibles a small amount based on their income and resources. Since then, for all QMBs, states may charge a "nominal" amount. 42 U.S.C. § 1396o.

7. The House Report, outlining the scope of the new QMB program, stated that states "would be permitted to pay just for the Medicare Part B premium and the other Parts A and B cost-sharing requirements for Medicare beneficiaries." H.R. Rep. No. 99-727, 99th Cong. 2d Sess. at 105 (1986), *reprinted in* 1986 U.S.C.C.A.N. 3607, 3695. Nothing in the surrounding discussion indicates that the states would be allowed to discretionarily *limit* the amount of cost-sharing they paid. *See Kozlowski*, 42 F.3d at 1455. Moreover, the House Report provided an example for how state Medicaid programs would be required to pay the cost-sharing amounts for QMBs, referencing Part B physician services:

> . . . for elderly and disabled individuals whom the state chose to cover, the Medicaid program would pay for the Part B deductible and the beneficiary's 20% coinsurance on Part B services. If the beneficiary uses a physician that takes assignment, Medicaid would pay the physician directly for the 20% coinsurance, and the patient could not be billed for any amounts above the Medicare reasonable charge.

H.R. Rep. No. 99-727, 99th Cong. 2d Sess. at 106 (1986), *reprinted in* 1986 U.S.C.C.A.N. 3607, 3696. This clearly indicates that physicians (and other providers) could expect to receive full payment for the QMBs whom the states were buying into the Medicare program.

expensive for the states. *See* H.R. Rep. No. 99-727, 99th Cong., 2d Sess. at 106 (1986), reprinted in 1986 U.S.C.C.A.N. 3607, 3696.

These clear statutory provisions and supporting contemporaneous legislative history are consistent with the Hospitals' position.[8] Unfortunately, they were ignored by the Ninth Circuit.[9] Rather than analyze the statutes in question, the Ninth Circuit appears to have thrown up its hands and expressed its frustration that "any quality of crystal clarity is uniformly recognized as totally absent from the Medicaid and Medicare statutes." 132 F.3d at 1266. Under the opinion's logic, the entirety of legislation for two federal programs becomes ambiguous, allowing federal and state agencies free reign to interpret those provisions as they see fit. That is clearly an unacceptable result.

Besides its general reluctance to wade into the statutory scheme, the Ninth Circuit focused on a provision of the Social Security Act, 42 U.S.C. § 1396a(n), which has been relied on by the state and federal defendants in all the litigation on this issue as a basis for limiting states' cost-sharing obligations. This provision was

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8. If any legislative history is to be considered in construing statutory meaning, this Court has held that it is preferable to consult the documents prepared by Congress when deliberating. *Gustafson v. Alloyd Co. Inc.*, 513 U.S. 561, 580, 115 S. Ct. 1061, 1072, 131 L. Ed. 2d 1 (1995). Some inconsistent post-enactment legislative history was considered by the Four Circuits, but rejected as unpersuasive. *See Kozlowski*, 42 F.3d at 1456-57 ("This wrenching change to a statute's meaning that had been stable for 20 years points precisely to the pitfalls of relying on 'post enactment legislative history' which Justice Scalia recently has characterized, quite appropriately, as an oxymoron."); *See also Haynes*, 36 F.3d 1076 (following *Snider*, 29 F.3d 886, and adopting its rationale); *Snider*, 29 F.3d at 898; *Perales*, 954 F.2d at 861.

9. The Seventh Circuit agreed with the providers that the requirement that states reimburse providers at the full Medicare level of payment can be naturally inferred from the statutory language. *Paramount*, 138 F.3d at 708.

carefully considered by the Four Circuits, which unanimously found that the underlying, mandatory obligation to pay full cost-sharing was unaffected by Section 1396a(n)'s terms.

Section 1396a(n) sets forth the following language:

> In the case of medical assistance furnished under this subchapter for medicare cost-sharing respecting the furnishing of a service or item to a qualified medicare beneficiary, the State plan may provide payment in an amount with respect to the service or item that results in the sum of such payment amount and any amount of payment made under subchapter XVIII [Medicare] of this chapter with respect to the service or item exceeding the amount that is otherwise payable under the State plan for the item or service for eligible individuals who are not qualified medicare beneficiaries.

See App. E. This statute declares that a state "may" make cost-sharing payments for QMBs which, together with the payment made by the Medicare program, can cause total payments to exceed the payments made for other Medicaid beneficiaries. California contends that the word "may" in this statute means that its obligation to cover cost-sharing for QMBs is permissive, rather than mandatory. None of the Four Circuits accepted this as a reasonable interpretation of Section 1396a(n).

In light of the mandatory nature of Sections 1396a(a)(10)(E)(i) and 1396d(p)(3), the contemporaneous legislative history, and the Medicare requirement that providers be reimbursed for 100% of their costs, the Four Circuits held that Section 1396a(n) had no impact on the requirement that states pay full cost-sharing for QMBs. Three of the four circuits reasoned that this statute allowed states to exceed their standard Medicaid rates for QMBs and allowed

providers to accept such higher payments.[10] Only the *Kozlowski* Court had a slightly different interpretation, finding that this statute allowed states to pay slightly more for pure QMBs than for dual eligibles. 42 F.3d at 1454. While the Hospitals concur with the prevailing view of the Second, Third and Eleventh Circuits, the significant fact is that *none* of the Four Circuits accepted the defendants' reading of Section 1396a(n) and that *all* of the Four Circuits *consistently* held that Section 1396a(n) could not reasonably be read to make a state's obligation to pay full cost-sharing discretionary.

Thus, the Ninth and Seventh Circuits' reasoning that the pre-BBA provisions were ambiguous regarding the states' cost-sharing obligation, which allowed them to defer to Section 4714's "clarification" and bypass the difficult constitutional questions which retroactive application raised, was not only unfounded, but also directly conflicts with the holdings of the Four Circuits. The Supreme Court should grant certiorari to resolve this conflict.

B. There Is A Conflict In This Court's Pronouncements Regarding The Deference Accorded To Congressional Enactments Which Purport To Clarify The Intent Of A Prior Congress.

The court below, and the *Paramount* court, resolved these cases by simply deferring to Congress' so-called "clarification" of the law expressed in Section 4714 of the BBA. Both courts felt

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10. The Ninth Circuit characterized the Second Circuit ("*Perales*") and the Third Circuit ("*Snider*") as having given different interpretations to Section 1396a(n). In fact, their interpretations were the same: *Perales* (954 F.2d at 860) found that the statute allowed states to exceed their Medicaid rates for QMBs, while *Snider* (29 F.3d at 895) found that the statute allowed providers to accept more than the Medicaid rates for QMBs; these are two sides of the same coin. *Haynes* (36 F.3d at 1076) directly followed the interpretation set forth in *Snider*.

constrained to grant such deference to Section 4714 because of a line of Supreme Court cases which have stated that legislation which expresses the intent of an earlier statute must be accorded great weight. *See, e.g., Loving v. United States*, 517 U.S. at __, 116 S. Ct. at 1749; *Red Lion Broadcasting Co. v. FCC*, 395 U.S. 367, 381-82 & n.8, 89 S. Ct. 1794, 1801-02 & n.8, 23 L. Ed. 2d 371 (1969). Both courts erred in applying this line of cases because an objective examination of Section 4714 demonstrates that it is truly a change in existing law, rather than merely the expression of an earlier Congress' intent, regardless of the "clarification" label.

It is perhaps understandable that the courts erroneously applied this standard, since this Court's guidance on the appropriate weight given to legislation purporting to interpret earlier enacted statutes has been somewhat dichotomous. As Judge Posner stated in *Paramount*, this Court's inconsistent decisions on this issue have placed the lower courts in a quandary, and clarification by the Court on this issue would be extremely helpful. 138 F.3d at 711. Without such elucidation, and if the decisions below are allowed to stand, Congress will feel increasingly emboldened to retroactively nullify, in the guise of "clarifications," previous statutes which have exceeded budgetary expectations or which have been given judicial interpretations disfavored by a subsequent Congress.

This Court has made unequivocal statements that the opinions of a subsequent Congress on the meaning of legislation enacted by an earlier Congress should have little, if any, significance. *See e.g., South Dakota v. Yankton Sioux Tribe*, 118 S. Ct. 789, 803-04, 139 L. Ed. 2d 733 (1998); *Public Employees v. Betts*, 492 U.S. 158, 168, 109 S. Ct. 2854, 2862, 106 L. Ed. 2d 134 (1989) ("We have observed on more than one occasion that the interpretation given by one Congress . . . is of little assistance in discerning the meaning of [a prior] statute."); *United States v. Philadelphia National Bank*, 374 U.S. 321, 348-49, 83 S. Ct. 1715, 1733, 10 L. Ed. 2d 915 (1963) ("The views of a subsequent

Congress form a hazardous basis for inferring the intent of an earlier one."). On the other hand, this Court has also stated that subsequent congressional views are entitled to "great weight" in construing the meaning of earlier statutes. *Loving v. United States*, 517 U.S. at __, 116 S. Ct. at 1749; *Consumer Product Safety Comm'n v. GTE Sylvania, Inc.*, 447 U.S. 102, 118 n.13, 100 S. Ct. 2051, 2061 n.13, 64 L. Ed. 2d 766 (1980). (*See* additional cases espousing both of these conflicting propositions, cited in the Petition for Certiorari filed by the California Ambulance Association and the California Medical Association.)

The Ninth Circuit attempted to harmonize these conflicting lines of cases on the grounds that those cases which question the value of the later Congress' opinion on an earlier statute have all involved attempts to use less formal types of subsequent legislative history, rather than subsequent statutes, to infer the meaning of prior enactments. 132 F.3d at 1259. However, as Judge Posner noted in the *Paramount* decision, some of the cases in the *Philadelphia National Bank* line give little weight to subsequent *legislation* as a guide to interpreting the intent of an earlier Congress, 138 F.3d at 710-11; *see, e.g., Yankton*, 118 S. Ct. at 803; *Rainwater v. United States*, 356 U.S. 590, 593, 78 S. Ct. 946, 949, 2 L. Ed. 2d 996 (1958); *see also Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 839-40, 108 S. Ct. 2182, 2190-91, 100 L. Ed. 2d 836 (1988).

Having given short shrift to the line of cases which minimizes the value of later Congressional enactments to interpret earlier ones, the court below simply gave "great weight" to Section 4714 for determining the meaning of pre-existing law.[11] The *Paramount* court had much more difficulty with this exercise, only reluctantly giving credit to Congress' purported clarification in Section 4714:

11. In fact, the Ninth Circuit only looked at the impact of Section 4714 on Section 1396(a)(n). It ignored the statutes which are the foundation of the states' obligation to pay full Medicare cost-sharing: Sections 1396(a)(10)(E)(i) and 1396(d)(p)(3).

> So we're in a quandary concerning the continued vitality of the *Loving* line and would welcome clarification from the Supreme Court — pending which we feel constrained by *Loving* to give *some* weight to Congress's declaration in the Balanced Budget Act that providers of services to quimbies are not entitled to reimbursement at full Medicare rates.

138 F.3d at 711.

The Seventh Circuit further pointed out specific reasons why little, if any, weight should be given to the pronouncement of the 1997 Congress on the prior meaning of the law. In fact, the Seventh Circuit stated that there is "an air of unreality in treating section 4714(a) as an attempted clarification of original statutory meaning," pointing out that the disputed statutory provisions were enacted 11 years before the BBA was passed. 138 F.3d at 709-710. Not only is there little continuity between the members of the 1986 Congress and the 1997 Congress, the issue is so esoteric that even remaining members of Congress would undoubtedly have little memory of what the original statutory language could have meant. The existence of such purported "clarifications" by subsequent Congresses, and Section 4714 is by no means an isolated example,[12] is a compelling reason for this Court to explain *Loving*. Otherwise, Congress can twist the meaning of earlier statutes, regardless of the age of those provisions.

Deferring to Section 4714 is especially egregious because the statute itself clearly demonstrates that it represents a change in law,

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12. The BBA contained numerous purported "clarifications" of earlier legislation, a number of which directly appear aimed at reversing intervening court decisions in order to save federal dollars. (*See* more detailed discussion of these additional clarifications in the Petition for Certiorari filed by the California Ambulance Association and the California Medical Association.)

rather than a true clarification. Indeed, Section 4714 does not even modify the language of the original Section 1396(a)(n) to provide the "cap" on the states' obligation which purportedly was always contained within it. To the contrary, Section 4714 adds a completely new provision to achieve that result. The new provision, designated subsection 1396a(n)(2), provides that the states may pay less than the full Medicare cost-sharing for QMBs. The original provision was kept intact (and re-numbered as 1396a(n)(1)). If the original provision was not rendered surplusage by Section 4714, a construction disfavored by *Morton v. Mancari*, 417 U.S. 535, 551, 94 S. Ct. 2474, 2483, 41 L. Ed. 2d 290 (1974), and *United States v. Menasche*, 348 U.S. 528, 538-39, 75 S. Ct. 513, 519-20, 99 L. Ed. 615 (1955), it must therefore serve the purpose it always served, *i.e.*, to make clear that the states would not be violating their own Medicaid plans when making QMB payments at the higher Medicare rate.

Further, the new subsection a(n)(2) specifically allows states to limit their cost-sharing for QMBs to the Medicaid rate for Medicaid beneficiaries who are not Medicare beneficiaries. Nothing in the previous law authorized states specifically to cap their reimbursement at such a level. Additionally, the establishment of an "effective" date for the new law (August 5, 1997), and the "retroactive" application in certain limited situations (*i.e.*, pending or subsequently filed litigation), belies the concept of the statute as a "clarification." If the statute were truly a clarification, it would not become effective as of the present enactment date; it would merely be a statement of what the law always was.

In addition to the specific reasons why it is illogical to consider Section 4714 as a true clarification of prior law, the context of this enactment undercuts its consideration as a clarification. As Judge Posner pointed out:

> The location of the 1997 amendments in a statute labeled the "Balanced Budget Act" and concerned primarily with cutting the federal deficit hardly

> creates confidence that Congress was, court-like, interpreting the 1986 statute. It is far more realistic to regard the 1997 quimby provisions as designed to change the original statute in order to reduce the cost of Medicaid to the federal government.

Paramount, 138 F.3d at 710.

The application of the *Loving* principle — giving deference, whether great or slight, to a statutory declaration regarding the meaning of prior law — is especially misguided here, when congressional action is so transparently an attempt to overturn the judicial construction of prior law. Certiorari should be granted so that this Court will have an opportunity to consider what strictures should be placed on Congress' ability to reinterpret existing laws.

II. THIS COURT SHOULD REVIEW THE CONSTITUTIONALITY OF BBA SECTION 4714(C) UNDER THE ARTICLE III SEPARATION OF POWERS DOCTRINE, TO CLARIFY THE SCOPE OF *UNITED STATES v. KLEIN*, 80 U.S. (13 WALL.) 128, 20 L. ED. 519 (1871), WHICH HAS BEEN CALLED INTO QUESTION BY THE COURT'S DECISIONS IN *ROBERTSON v. SEATTLE AUDUBON SOC'Y*, 503 U.S. 429, 441, 112 S. CT. 1407, 1414, 118 L. ED. 2D 73 (1992) AND *PLAUT v. SPENDTHRIFT FARM, INC.*, 514 U.S. 211, 115 S. CT. 1447, 1452 (1995).

Congress has given Section 4714 an effective date of August 5, 1997, but has commanded the courts to apply one of Section 4714's provisions retroactively to payments for health services provided before enactment. Congress has applied this amendment to pending litigation, without repealing or amending the old law. Moreover, the change is to Congress' and the states' fiscal advantage. Congress has compelled this particular reading of the

statutes here at issue in the face of the Four Circuits' decisions holding that the prior law clearly required a different result. Petitioners believe such legislation violates the separation of powers proscription in *United States v. Klein*. If it does not, very little remains of the *Klein* prong of the Separation of Powers Doctrine.

In *Klein*, this Court held that Congress may not prescribe rules of decision for the courts. *Klein* occurred in the wake of the Civil War when Congress enacted legislation giving former owners of property seized by the government, with proof of loyalty, the right of action to recover proceeds from the federal government's sale of their property. This Court held that a presidential pardon was sufficient proof of loyalty entitling its recipient to recover. *United States v. Padelford*, 76 U.S. (9 Wall.) 531, 542-43, 19 L. Ed. 788 (1869). In 1865, Klein filed a petition to collect the proceeds from the sale of cotton seized by the Union during the war. In 1868, the Court of Claims determined that a presidential pardon entitled the estate to recover the proceeds. Pending the government's appeal from that judgment to this Court, Congress enacted a statute providing that no presidential pardon should be admissible as proof of loyalty, that acceptance of such a pardon should be conclusive evidence of the claimant's disloyalty, and the Court of Claims and this Court must dismiss for want of jurisdiction any pending claims based on a presidential pardon. Act of July 12, 1870, ch. 251, 16 Stat. 235; *see Klein*, 80 U.S. (13 Wall.) at 132-34, 143-44. This Court declared the 1870 statute unconstitutional. The Court stated that Congress had exceeded its constitutional power to limit the Court's appellate jurisdiction:

> It is evident . . . that the denial of jurisdiction to this court, as well as to the Court of Claims, is founded solely on the application of a rule of decision, in causes pending, prescribed by Congress. The court has jurisdiction of the cause to a given point; but when it ascertains that a certain state of

> things exist, its jurisdiction is to cease and it is required to dismiss the cause for want of jurisdiction.
>
> It seems to us that this is not an exercise of the acknowledged power of Congress to make exceptions and prescribe regulations to the appellate power.
>
> . . . .
>
> Can [Congress] prescribe a rule in conformity with which the court must deny to itself the jurisdiction thus conferred, because and only because its decision, in accordance with settled law, must be adverse to the government and favorable to the suitor? The question seems to us to answer itself.

Klein, 80 U.S. (13 Wall.) at 146-47.[13]

Some noted legal commentators have found that *Klein* "is not a model of clarity." Paul M. Bator, Paul J. Mishkin, Daniel J. Meltzer & David L. Shapiro, *Hart & Wechsler's The Federal Courts and the Federal System* 369 (3d edition 1988). Even this Court has not uniformly described the *Klein* proscription against certain legislation. The Court has, on occasion, treated the decision narrowly, holding that Congress may not "attempt to prescribe to the judiciary the effect to be given to a [presidential] pardon, in regard to a matter in which the pardon extended." *Hart v. United States*, 118 U.S. 62, 6 S. Ct. 961, 963, 30 L. Ed. 96 (1886); *see Public Citizen v. United States Dep't of Justice*, 491 U.S. 440, 485, 109 S. Ct. 2558, 2582-83, 105 L. Ed. 2d 377 (1989) (Kennedy, J., concurring in the judgment). *Klein* also has been described as holding that Congress may not "attempt to invade the

13. Secondarily, the court found that the rule of decision at issue, which impaired the effect of a pardon, also impermissibly infringed on the constitutional power of the executive. *Id.* at 147.

judicial province by prescribing a rule of decision in a pending case." *Glidden Co. v. Zdanok*, 370 U.S. 530, 568, 82 S. Ct. 1459, 1482, 8 L. Ed. 2d 671 (1962) (plurality opinion).

In 1980, this Court read *Klein* as an amalgam of these rationales: Congress may not "prescribe . . . a rule of decision in a case pending before the courts, . . . in a manner that required the courts to decide a controversy in the Government's favor." *United States v. Sioux Nation*, 448 U.S. 371, 404, 100 S. Ct. 2716, 2735-36, 65 L. Ed. 2d 844 (1980). The Court found "of obvious importance" to the *Klein* holding, that "Congress was attempting to decide the controversy in [its] own favor." 448 U.S. at 405, 100 S. Ct. at 273. Thus, Congress' action was not grounded in any broad power conferred on it by the Constitution. *Id. Sioux Nation* was perhaps this Court's most complete description of the meaning of the proscription in *Klein*. Unfortunately, the Court's next two opportunities to address the *Klein* prong of the separation of powers doctrine have created some confusion.

In *Seattle Audubon Soc'y v. Robertson*, 914 F.2d 1311 (9th Cir. 1990), *rev'd*, 503 U.S. 429 (1992) the Ninth Circuit had an opportunity to review this Court's separation of powers jurisprudence, including *Klein* and its progeny. In that case, the Ninth Circuit, and subsequently this Court, considered the constitutionality of Section 318 of the Department of the Interior and Related Agencies Appropriations Act of 1990, Pub. L. 101-121, § 318, 103 Stat. 745-50 (1989). In Section 318(b)(6)(A), Congress:

> Determine[d] and direct[ed] that management of areas according to subsections (b)(3) and (b)(5) of this section on the thirteen national forests in Oregon and Washington and [BLM] lands in western Oregon known to contain northern spotted owls *is adequate consideration for the purpose of meeting the*

> *statutory requirements that are the basis for [various federal court actions].* (Emphasis added.)[14]

The Ninth Circuit found that Section 318 "directs the court to reach a specific result and make certain factual findings under existing law in connection with . . . cases pending in federal court" contrary to the Supreme Court's holding in *Klein*, 914 F.2d at 1316.

This Court reviewed the Ninth Circuit's *Seattle Audubon* decision and overturned it. 503 U.S. 429, 112 S. Ct. 1407, 118 L. Ed. 2d 73 (1992). The linchpin of the Court's decision was whether the statutory provision in question "compelled changes in law, not findings or results under old law." 503 U.S. at 438, 112 S. Ct. at 1413. The Court held:

> We have no occasion to address any broad question of Article III jurisprudence. The Court of Appeals held that subsection (b)(6)(A) was unconstitutional under *Klein* because it directed decisions in pending cases without amending any law. Because we conclude that subsection (b)(6)(A) did amend applicable law, we need not consider whether this reading of *Klein* is correct.[15]

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14. That section

> sets terms and conditions applicable only for fiscal year 1990 for making timber sales on federal lands in Oregon and Washington, for managing habitat for northern spotted owls, and minimizing fragmentation of significant old-growth forests stands.

H.R. Conf. Rep. No. 101-264, 101st Cong., 1st Sess. 87 (1989).

15. In reviewing the statutory change, the Court noted:

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503 U.S. at 441, 112 S. Ct. at 1414. The Court recognized a prospective temporary suspension of the law as a repeal or amendment that satisfied some of the *Klein* Court's concerns under Article III. At the same time, the Court called into question whether, even if the Ninth Circuit had correctly characterized Section 318, a *Klein* constitutional violation by Congress would be found by this Court. *Id.*

Five years later, in *Plaut v. Spendthrift Farm, Inc.*, 514 U.S. 211, 115 S. Ct. 1447, 131 L. Ed. 2d 328 (1995), the Court had occasion to consider the constitutionality of Congress' decision to reopen final judicial decisions. In the course of finding such a provision unconstitutional, the Court questioned the scope of *Klein*:

> Our decisions to date have identified two types of legislation that require federal courts to exercise the judicial power in a manner that Article III forbids. It first appears in *United States v. Klein* . . . , where we refused to give effect to a statute that was said "[t]o prescribe rules of decision to the judicial department

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> Before [the] subsection . . . was enacted, the original claims would fail only if the challenged harvesting violated none of five old provisions. Under [the] subsection . . . by contrast, those claims would fail if the harvesting violated neither of these two new provisions. Its operation, we think, modified the old provisions. Moreover, we find nothing in [the] subsection . . . that purported to direct any particular findings of fact or applications of law, old or new, to fact. For challenges to sales offered before and after fiscal year 1990, [the] subsection expressly reserved judgment upon "the legal and factual adequacy" of the administrative documents authorizing the sales. For challenges to sales offered during fiscal year 1990, subsection (g)(1) expressly provided for judicial determination of the lawfulness of those sales.
>
> 503 U.S. at 438-39, 112 S. Ct. at 1413.

> of the government in cases pending before it." *Id.* at 146. Whatever the precise scope of *Klein*, however, later decisions have made clear that its prohibition does not take hold when Congress "amend[s] applicable law." *Robertson v. Seattle Audubon Soc'y*, 503 U.S. 429, 441, 112 S.Ct. 1407, 1414, 118 L.Ed.2d 73 (1992).

514 U.S. at 218, 112 S. Ct. at 1452.

These cases presented the Court with the opportunity to provide direction to the lower courts by clarifying the scope of *Klein*.[16] The legislation here at issue clearly did not change the existing law as to services provided before enactment. Indeed, under Section 4717(c), Congress' reading of the old law applies only in states where litigation is filed, and only as to those providers who have initiated litigation. As to other states, the executive branch of the federal government, and those providers who do not file a lawsuit, Congress' reading of the old law does not apply to services provided before the date of enactment. The legislation here at issue is easily distinguishable from *Seattle Audubon Soc'y*, where Congress directed a prospective and time-limited change in the law, without directing an outcome as to litigation under previous statutory standards, or even standards that would be reinstated after the legislation sunsets. Instead, here, Congress did precisely what *Klein* prohibits. It did not repeal or otherwise amend the prior law with respect to nonlitigants or the executive branch; it simply directed that as to litigants the law meant a particular thing. Under Article III, that is the province of the courts and not Congress.

The additional element that concerned the *Klein* and *Sioux Nation* Courts is also present here. Congress is not acting to further

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16. The Ninth Circuit went to extreme lengths to avoid addressing these constitutional issues. Judge Posner, in *Paramount*, ruminated on the *Klein* type of separation of powers problem involved in this case, without ever resolving the issue. 138 F.3d at 710.

one of its constitutionally imposed responsibilities. Rather, it is acting to benefit the government in a dispute that would otherwise not be decided in its favor.

If the Court allows this naked exercise by the Congress of the judicial function to stand, we will have lost a significant check on overreaching conduct by the coordinate branches of government. The need to distribute and apportion the activities of government goes to the very structure of the Constitution. James Madison warned that "the accumulation of all powers . . . in the same hands, whether of one, a few, or many . . . may justly be pronounced the very definition of tyranny." The Federalist No. 47, at 322. That is precisely the kind of concern this Court addressed in *Klein* by refusing to allow Congress to manipulate the outcome of litigation to the government's advantage.

Given the lower courts' confusion regarding the reach of *Klein's* constitutional proscription, and Congressional interference with a judicial function through appropriations legislation that changes of the terms of Congress' bargain with an entire industry, review by this Court is warranted.

III. BY DEFERRING TO THE CONGRESSIONAL "CLARIFICATION", THE NINTH CIRCUIT IGNORED THE CONSTITUTIONAL TAKING PROBLEM WHICH WILL RESULT IN THE DISENTITLEMENT OF PROVIDERS TO FUNDS TO WHICH THEY WERE ENTITLED UNDER THE PRE-ENACTMENT STATUTES.

The Ninth Circuit's opinion below barely acknowledged, and did not address, the serious Constitutional takings issue raised by Congress' effort to label Section 4714 as a "clarification" of prior law. Instead of considering the existence of this issue as a factor which might militate against judicial deference to the legislature,

the court below found that it must "honor Congress' 'clarification' label . . . [which] moots all of appellees' constitutional objections to the new legislation." 132 F.3d at 1266. In so doing, the Ninth Circuit ignored a recently-affirmed line of this Court's decisions invalidating efforts by Congress to repudiate the contractual obligations of the United States.

This Court recently reiterated that government may not retroactively reduce or eliminate its own debts to save money. *See United States v. Winstar Corp.*, 518 U.S. 839, __, 116 S. Ct. 2432, 2459-60 and n.28, 2464-65 and n.39, 2468-69 n.51 (plurality opinion), 2475-76 (Breyer, J. concurring), 2478-79 (Scalia, J. concurring, joined by Kennedy, J. and Thomas, J.), 135 L. Ed. 2d 964 (1996). This Court found that the most protectable of government contracts with private parties are those in procurement or related situations. 518 U.S. at __, 116 S. Ct. at 2457. All four opinions in that case recognized such rights as protected against retroactive abrogation by the sovereign, relying on this Court's uncontroverted decisions in *Lynch v. United States*, 292 U.S. 571, 54 S. Ct. 840, 78 L. Ed. 1434 (1934) and *Perry v. United States*, 294 U.S. 330, 55 S. Ct. 432, 79 L. Ed. 912 (1935) ("the two principal cases of this century holding that the government may not simply repudiate its contractual obligations"). 518 U.S. at __, 116 S. Ct. at 2479. Both *Lynch* and *Perry* make clear that congressional abrogation of the "essential bargain" of a contract is an "impermissible repudiation." *Id*; *see Perry*, 294 U.S. at 350-354, 55 S. Ct. at 434-437; *Lynch*, 292 U.S. at 578-580, 54 S. Ct. at 843-844.

Here, the United States and California seek to avoid, through Section 4714, contractual rights even more worthy of protection than the prospective insurance benefits at issue in *Lynch*. *See* 292 U.S. at 580-81, 54 S. Ct. at 843-844. In this case, the medical services already have been provided, as even Congress recognized. BBA § 4714(c) (amendments "shall also apply to payment by a

State for items and services furnished before" the date of enactment if the subject of a lawsuit).

The law existing when the Hospitals provided services, 42 U.S.C. §§ 1396a(a)(10)(E)(i) and 1396d(p)(3), required payment to the Hospitals at the Medicare rate — including Part A cost-sharing from state and federal Medicaid funds. The Hospitals' rights to payment were vested.[17] An implied contract arises after services are rendered under a law specifying compensation to be paid at the amount fixed. *See Robertson v. Miller*, 276 U.S. 174, 179, 48 S. Ct. 266, 268, 72 L. Ed. 517 (1928).

The present deprivation is more direct, more immediate and less justifiable than the taking in either *Lynch* or *Perry*. Congress and California are walking away from debts to providers that were induced to provide hospital services to QMBs. The benefit that the United States will derive from retroactive application of Section 4714 cannot be overlooked. "[I]t makes sense to scrutinize governmental action more closely when the State stands to benefit."

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17. In describing this contractual relationship and the function of the Medicare Provider Agreements that form a part of it, the courts have explained that

> (t)he Provider agreement is a *unique type of contract*. It does not provide for a defined transaction or even a series of transactions. It . . . establishes a relationship between the parties: if [the provider] treats eligible patients, HHS will reimburse them for their costs.

University Medical Center v. Sullivan, 973 F.2d 1065, 1081 (3d Cir. 1992) (emphasis added). In effect, the Medicare Provider Agreement is deemed an "executory contract" between the provider and the government. *Id.* at 1076-1077; *see also California Medical Ass'n v. Lackner*, 117 Cal. App. 3d 552, 556-61, 172 Cal. Rptr. 815, 818-21 (1981) (Medicaid program regulations "amount to an offer which, when accepted by performance, culminates in a contract between the government and the offeree").

Harmelin v. Michigan, 501 U.S. 957, 978 n.9, 111 S. Ct. 2680, 2693 n.9, 115 L. Ed. 2d 836 (1991) (citing *Perry*, 294 U.S. at 350-51, 55 S. Ct. at 435). The United States will avoid the obligation to pay matching funds to the states through the effectof Section 4714, as Exhibit F indicates.

The Ninth Circuit's failure to address these Constitutional concerns elevates deference to a purported Congressional clarification above Petitioners' vested property interests. Certiorari should be granted to establish the vitality of *Lynch* and *Perry* in these circumstances.

CONCLUSION

For the foregoing reasons, the writ of certiorari should issue to review the judgment of the United States Court of Appeals for the Ninth Circuit.

Respectfully submitted,

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Dated: June 1, 1998

APPENDIX

APPENDIX A — OPINION OF THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT FILED DECEMBER 2, 1997

FOR PUBLICATION

UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BEVERLY COMMUNITY HOSPITAL ASSOCIATION, a California non-profit public benefit corporation, d/b/a BEVERLY HOSPITAL; BELLWOOD MEDICAL CORPORATION, d/b/a BELLWOOD GENERAL HOSPITAL; CHICO COMMUNITY HOSPITAL MEDICAL CENTER, INC., d/b/a CHICO COMMUNITY REHABILITATION HOSPITAL, d/b/a CHICO COMMUNITY HOSPITAL; HOLLYWOOD COMMUNITY HOSPITAL MEDICAL CENTER, INC., d/b/a HOLLYWOOD COMMUNITY HOSPITAL OF VAN NUYS, d/b/a HOLLYWOOD COMMUNITY HOSPITAL OF HOLLYWOOD; LANCASTER HOSPITAL CORPORATION, d/b/a LANCASTER COMMUNITY HOSPITAL, et al.,

Plaintiffs-Appellees,

v.

KIMBERLY BELSHE, Director of the California Department of Health Services,

Defendant-Appellant.

No. 96-55208

D.C. No. CV-95-04053-JSL

OPINION

Appendix A

CALIFORNIA AMBULANCE ASSOCIATION, *Plaintiff-Appellee,* v. DONNA E. SHALALA, Secretary of the United States Department of Health and Human Services, *Defendant,* and KIMBERLY BELSHE, Director of the California Department of Health Services, *Defendant-Appellant.*	No. 96-56249 D.C. No. CV-96-02322-JSL
CALIFORNIA AMBULANCE ASSOCIATION, *Plaintiff-Appellee,* v. DONNA E. SHALALA, Secretary of United States Department of Health and Human Services, *Defendant-Appellant.*	No. 96-56485 D.C. No. CV-96-2322-JSL

Appendix A

CALIFORNIA MEDICAL ASSOCIATION; CALIFORNIA ACADEMY OF FAMILY PHYSICIANS; CALIFORNIA SOCIETY OF ANESTHESIOLOGISTS; CALIFORNIA UROLOGICAL ASSOCIATION; CALIFORNIA CHAPTER OF THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS; CALIFORNIA CHAPTER OF THE AMERICAN COLLEGE OF CARDIOLOGY; CALIFORNIA SOCIETY OF INTERNAL MEDICINE; CALIFORNIA SOCIETY OF PHYSICAL MEDICINE & REHABILITATION; CALIFORNIA RADIOLOGY SOCIETY, CHAPTER OF THE AMERICAN COLLEGE OF RADIOLOGY,
Plaintiffs-Appellees,

v.

DONNA E. SHALALA, Secretary of United States Department of Health and Human Services; S. KIMBERLY BELSHE, Director of the California Department of Health Services,
Defendants-Appellants.

No. 96-56648

D.C. No. CV-03033-JSL

Appendix A

RICHARD GILMORE, M.D.; SARAF PROTAP, M.D., *Plaintiffs-Appellees,* v. DONNA E. SHALALA, Secretary of the United States Department of Health and Human Resources, *Defendant,* S. KIMBERLY BELSHE, Director of Health Services, *Defendant-Appellant.*	No. 96-56699 D.C. No. CV-96-05564-JSL
RICHARD GILMORE, M.D., individually and on behalf of all those similarly situated; PRATAP SARAF, M.D., individually and on behalf of all those similarly situated, *Plaintiffs-Appellees,* v. DONNA E. SHALALA, Ph.D., Secretary of the United States Department of Health and Human Services; S. KIMBERLY BELSHE, Director of the California Department of Health Services, *Defendants-Appellants.*	Nos. 96-56745 97-55220 D.C. No. CV-96-05564-JSL

Appendix A

CALIFORNIA MEDICAL ASSOCIATION; CALIFORNIA ACADEMY OF FAMILY PHYSICIANS; CALIFORNIA SOCIETY OF ANESTHESIOLOGISTS; CALIFORNIA UROLOGICAL ASSOCIATION; CALIFORNIA CHAPTER OF THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS; CALIFORNIA CHAPTER OF THE AMERICAN COLLEGE OF CARDIOLOGY; CALIFORNIA SOCIETY OF INTERNAL MEDICINE; CALIFORNIA SOCIETY OF PHYSICAL MEDICINE & REHABILITATION; CALIFORNIA RADIOLOGY SOCIETY, CHAPTER OF THE AMERICAN COLLEGE OF RADIOLOGY, *Plaintiffs-Appellees,* v. DONNA E. SHALALA, Secretary of the United States Department of Health and Human Services, *Defendant-Appellant.*	No. 97-55022 D.C. No. CV-96-03033-JSL
DONALD R. MACPHERSON, JR., as Successor in interest to decedent Christina MacPherson & MacPherson Oil Company Employee Welfare Benefit Plan, *Plaintiff-Appellant,* v. EMPLOYERS HEALTH INSURANCE, *Defendant-Appellee.*	No. 97-55713 D.C. No. CV-97-00514-JSL

Appendix A

Appeal from the United States District Court
for the Central District of California
J. Spencer Letts, District Judge, Presiding

Argued and Submitted
October 6, 1997—Pasadena, California

Filed December 2, 1997

Before: Stephen Reinhardt and A. Wallace Tashima,
Circuit Judges, and Milton I. Shadur, District Judge.*

Opinion by Judge Shadur

SUMMARY

Health/Medicaid/MediCare and Government Assistance

The court of appeals reversed judgments of the district court. The court held that amendments to the Medicare Act in the Balanced Budget Act of 1997 allows a participating state to limit beneficiary enrollment payments under the Medicare Act's cost-sharing provision to the amount by which the state's Medicaid rate exceeds what Medicare has paid.

In § 1396a(n) of the Medicare Act, Congress dealt with persons who are eligible for both Medicare (federal health insurance program for elderly and disabled) and Medicaid (cooperative federal-state program providing matching funds to states that elect to provide medical services to needy persons). Section 1396a(n) describes what the state plans can set up to cover their obligations on behalf of qualified medical beneficiaries (QMBs).

*The Honorable Milton I. Shadur, United States District Judge for the Northern District of Illinois, sitting by designation.

Appendix A

Appellant Secretary of the Department Health and Human Services took the legal position that under § 1396a(n), participating states have the choice to limit their cost-sharing payments for enrollment of QMBs to the amount by which the state's Medicaid rate exceeds what Medicare has paid. This is the interpretation under which California adopted "Medi-Cal," its Medicaid plan.

In a number of federal lawsuits, appellee Beverly Community Hospital Association and other Medicare and Medicaid providers challenged the reading of § 1396a(n) given by the Secretary and appellee Director of the California Department of Health Services. In each case, the district court rejected the Secretary's interpretation that under § 1396a(n), participating states have the choice to limit their payments so that they need not pay the full cost-sharing amount.

While the cases were pending on appeal, Congress passed the Balanced Budget Act of 1997 (BBA). Included in the statute as Act 4714 is a provision that expressly amends § 1396a(n) to adopt the Secretary's position, and expressly applies to pre-enactment state payments that were the subject of litigation pending on the date of enactment. Congress captioned the new provision a "clarification" regarding state liability for Medicare cost-sharing.

The central issue on appeal was whether the BBA requires application of the Secretary's interpretation of the pre-enactment version of the Medicare statute.

[1] It did not matter whether congressional labeling of the new legislation as a "clarification" had to be credited by a court. What was significant was that Congress's characterization reflected its intention to resolve every still-live dispute in the manner specified. The statutory reference to "pending" lawsuits had to be construed as embracing cases undecided at the district court level and actions pending on appeal.

[2] Because Congress has the authority to change the law as to pending cases, its power to clarify the law—to confirm what the law has always meant—follows a fortiori. [3] If Act 4714 were to be characterized as a substantial change in the law, its retroactive application would have posed potential constitutional problems. If it merely clarified what § 1396a(n) was intended to mean, the Medicaid Act never required states to pay cost-sharing in full.

[4] Congress expressly stated as its intention that the new provision in Act 4714 was a "clarification" of the payment rules contained in § 1396a(n). Congressional legislation that thus expresses the intent of an earlier statute must be accorded great weight.

[5] The argument, that § 4714 effected such a substantial change in terms of the government's liability to health care providers that it could not be treated as clarifying § 1396a(n), proceeded from the premise that § 1396a(n)'s meaning was clear enough so as to need no further explanation. That premise ignored the split of authority construing the statute. Clarity is absent from the Medicare and Medicaid statutes.

[6] Section 1396a(n) was particularly resistant to a single interpretation, and particularly in need of clarification. [7] Given the difficulty that courts have had in divining the intent of the original Congress, a decision by the current Congress to intervene by expressly clarifying the meaning of § 1396a(n) was worthy of real deference.

[8] Act 4714's provisions are a statement of what § 1396a(n) meant all along. That mooted all constitutional objections to the new legislation because they rested on the assertedly retroactive nature of Act 4714.

[9] Any claim that California was violating the new federal statute represented the basis for a new lawsuit. Any such claim called for the generation of a new record, against which

the trial court could determine whether there was anything to the contention that Act 4714's clarification of prior law somehow rendered invalid the Medi-Cal reimbursement methodology for hospitals. The trial court would also have to determine whether that argument might have been forfeited by not raising it the first time around.

COUNSEL

Beverly v. Belshe

Laurie R. Pearlman, California Attorney General, Los Angeles, California, for the defendant-appellant.

John R. Hellow and Kevin M. Corbett, Hooper, Lundy & Bookman, Inc., Los Angeles, California, for the plaintiffs-appellees.

Alissa B. Klein, United States Department of Justice, Civil Division, Washington, D.C.; Sanford E. Pitler, Bennett & Bigelow, D.S., Seattle, Washington, for the amicus.

CAA v. Belshe and Shalala

Charlton G. Holland III and Ralph Johnson, California Attorney General, San Francisco, California; Alissa B. Klein, United States Department of Justice, Civil Division, Washington, D.C., for the defendants-appellants.

William J. Bush, Hanson, Bridgett, Marcus, Vlahos & Rudy, LLP, San Francisco, California, for the plaintiffs-appellees.

Gilmore v. Belshe and Shalala

Charlton G. Holland III and Ralph Johnson, California Attorney General, San Francisco, California; Alissa B. Klein,

Appendix A

United States Department of Justice, Civil Division, Washington, D.C., for the defendants-appellants.

Michael A. Greene, Greenburg, Glusker, Fields, Claman & Machtinger LLP, Los Angeles, California; Bruce S. Sperling, Sperling, Slater & Spitz, P.C., Chicago, Illinois; Harvey J. Barnett, Harvey J. Barnett & Associates, P.C., Chicago, Illinois, for the plaintiff-appellee.

OPINION

SHADUR, District Judge:

We address here a question of first impression, not only in this Circuit but (understandably in light of the recency of the legislation involved) in any court: whether a congressional enactment adopted in August 1997, but stating that it is retroactive and applicable to pending cases, calls for approval of the reading that has been given to the pre-enactment version of the same legislation by the Secretary of the United States Department of Health and Human Services ("Secretary"). Because we answer that question in the affirmative, we reverse all three decisions below.[1]

All three of these sets of appeals pose a common problem: whether the State of California may choose to limit certain payments, as required by statute to be made to enroll poor people—qualified Medicare beneficiaries ("QMBs")—in the Medicare insurance program, to the amount by which California's Medicaid rate exceeds what Medicare has paid. Those payments, required from all participating states under the Medicaid Act, extend to deductibles, coinsurance and copayments that the QMBs cannot bear fully and that the State is

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[1] In each instance the jurisdiction of the district court was based upon 28 U.S.C. §1331. All three judgments are appealable pursuant to 28 U.S.C. §1291.

required to pay on their behalf (whether totally or in part is at stake in these cases).

Title XVIII of the Social Security Act (the "Medicare Act," 42 U.S.C. §§1395-1395ccc[2]) provides a federal health insurance program for elderly and disabled persons. Medicare Part A covers inpatient hospital services and certain related benefits (Sections 1395c-1395i-4), and it is provided automatically for individuals entitled to Social Security retirement or disability benefits (Section 426). Medicare Part B is a voluntary program under which Medicare-eligible persons can obtain supplemental insurance for various outpatient services from physicians and other providers (Sections 1395j-1395w-4). It is financed by a combination of federal funds and premiums paid by or on behalf of eligible individuals (Sections 1395r, 1395t(g)). Both Medicare Part A and Medicare Part B call for payments by covered individuals that constitute the deductibles, coinsurance and copayments referred to earlier.

Title XIX of the Social Security Act (the "Medicaid Act," Sections 1396-1396v) is a cooperative federal-state program that provides federal matching funds to states that elect to provide medical services to certain needy individuals (see Section 1396; *Harris v. McRae*, 448 U.S. 297, 301 (1980)). Although states are not required to participate in Medicaid, if they elect to do so they must follow federal guidelines (*Harris*, 448 U.S. at 301) and must submit for Secretary's approval their state plans that describe the states' intended means for insuring compliance with those guidelines (Section 1396a(b)).

What is at issue in these three sets of appeals is the area of overlap between the Medicare and Medicaid Acts where coverage for the elderly poor is involved. Those persons are often

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[2]All further citations to Title 42 provisions will take the form "Section —," utilizing the Title 42 numbering system rather than the internal numbering of the Acts involved.

entitled to participate in such coverage but may not be able to afford to pay the required deductible and coinsurance amounts under Medicare Part A or the premiums and payments needed to enroll in Medicare Part B. At the time that the various lawsuits were filed below, Congress had dealt with individuals who are eligible for both Medicare and Medicaid (see Section 1396d(p)(1)) by stating in Section 1396a(n) of the Medicaid Act what the state plans could set up to cover their obligations on behalf of the QMBs involved.

Three types of plaintiffs (now appellees) are involved in these appeals. *Beverly Hospital* is a class action on behalf of all California hospitals that provide inpatient hospital services under the Medicare and Medicaid Acts. *California Ambulance* involves two types of associations, California Ambulance Association and physician associations including California Medical Association, each type of association also representing providers of services under the two statutes. And *Gilmore* was brought by two doctors who provide outpatient physician services to persons under the two statutes.[3] Thus *Beverly Hospital* involves Medicare Part A, while *California Ambulance* and *Gilmore* implicate Medicare Part B.

Secretary is an appellant in all of the cases except for *Beverly Hospital*, in which she was given leave to participate as an amicus curiae. Director S. Kimberly Belshe of the California Department of Health Services ("Director") is an appellant in all of the cases. Both appellants subscribe to Secretary's legal position pursuant to which California adopted its Medicaid state plan ("Medi-Cal"), which position asserts that under Section 1396a(n) participating States such as California have the choice to limit their payments as described earlier, so that they need not pay the *full* cost-

[3]Although the *Gilmore* case was originally intended to be a class action, any need for class certification was obviated when defendants agreed that the result in the case would be followed as to all persons providing such services.

sharing amount. In each of the cases before us the District Court rejected that contention, as have all four Courts of Appeals that have addressed the question: *Rehabilitation Ass'n of Virginia, Inc. v. Kozlowski*, 42 F.3d 1444 (4th Cir. 1994)("*Kozlowski*"); *Haynes Ambulance Serv., Inc. v. State of Alabama*, 36 F.3d 1074 (11th Cir. 1994)("*Haynes*"); *Pennsylvania Med. Soc'y v. Snider*, 29 F.3d 886 (3d Cir. 1994)("*Snider*"); and *New York City Health and Hosps. Corp. v. Perales*, 954 F.2d 854 (2d Cir. 1992)("*Perales*").[4]

After the scheduled briefing of these appeals had been completed, Congress entered the picture. Its Balanced Budget Act of 1997 ("Act"), signed into law by the President on August 5 of this year, included as Act §4714 a provision that expressly amends Section 1396a(n) to adopt the position advanced by Secretary and Director here:

> (2) In carrying out paragraph (1), a State is not required to provide any payment for any expenses incurred relating to payment for deductibles, coinsurance, or copayments for medicare cost-sharing to the extent that payment under title XVIII for the service would exceed the payment amount that otherwise would be made under the State plan under this title for such service if provided to an eligible recipient other than a medicare beneficiary.
>
> (3) In the case in which a State's payment for

[4]Although this does not affect our resolution of these cases in light of what follows, it is worth noting that those four Courts of Appeals have employed divergent approaches (reading the statute differently) in reaching their conclusions. And it may be added that those four decisions (and the decisions now on appeal) do not at all reflect a unanimous judicial reaction: For example, two recent District Court decisions, *Dameron Physicians Med. Group v. Shalala*, 961 F.Supp. 1326 (N.D. Cal. 1997) and *Kulkarni v. Leean*, No. 96 C 884-S, 1997 WL 527674 (W.D. Wis. June 23), have joined other lower court decisions going the other way. See also the discussion of the problem at 66 U.S.L.W. 2233 (Oct. 21, 1997).

medicare cost-sharing for a qualified medicare beneficiary with respect to an item or service is reduced or eliminated through the application of paragraph (2)—

> (A) for purposes of applying any limitation under title XVIII on the amount that the beneficiary may be billed or charged for the service, the amount of payment made under title XVIII plus the amount of payment (if any) under the State plan shall be considered to be payment in full for the service;
>
> (B) the beneficiary shall not have any legal liability to make payment to a provider or to an organization described in section 1903(m)(1)(A) for the service; and
>
> (C) any lawful sanction that may be imposed upon a provider or such an organization for excess charges under this title or title XVIII shall apply to the imposition of any charge imposed upon the individual in such case.
>
> This paragraph shall not be construed as preventing payment of any medicare cost-sharing by a medicare supplemental policy or an employer retiree health plan on behalf of an individual.

There is no dispute among the litigants that if this new statutory provision (which Congress has captioned "Clarification Regarding State Liability for Medicare Cost-Sharing") is applicable, it requires the reversal of the District Court's decisions. One minor variant exists: Beverly Hospital contends that a remand is necessary because Secretary's methodology,

as applied to that hospital's situation, does not mesh with the new enactment. We speak briefly to that question later.

Because Congress was deliberately targeting what were known to be existing disputes on this subject, Act §4714(c) went on to prescribe a retroactive effective date of the quoted amendment:

> (c) EFFECTIVE DATE.—The amendments made by this section shall apply to payment for (and with respect to provider agreements with respect to) items and services furnished on or after the date of the enactment of this Act. The amendments made by subsection (a) shall also apply to payment by a State for items and services furnished before such date if such payment is the subject of a law suit that is based on the provisions of sections 1902(n) and 1905(p) of the Social Security Act[5] and that is pending as of, or is initiated after, the date of the enactment of this Act.

That being the case, the relevant considerations in our three cases have shifted from those that had occupied the parties' entire scheduled briefing, which (as stated earlier) had been completed before the congressional enactment. We therefore invited and received supplemental briefing on the effect of Act §4714 on these cases. And having done so, we eschew any analysis of those original arguments and turn instead to the validity and applicability of the August 1997 enactment.

Standard of Review

Both because constitutional questions are at issue and

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[5]Those cited sections of the Social Security Act respectively correspond to Sections 1396a(n) and 1396(d) in the Title 42 usage employed in this opinion. Those sections are in fact the statutory provisions involved in these appeals.

because the cases come up on summary judgment, we engage in a de novo review of the district courts' final judgments (*Gray v. First Winthrop Corp.*, 989 F.2d 1564, 1567 (9th Cir. 1993) ("The constitutionality of a statute is a question of law which we review de novo"); *Brinson v. Linda Rose Joint Venture*, 53 F.3d 1044, 1047 (9th Cir. 1995) (holding that an order granting summary judgment is reviewed de novo)). Each of the issues before us will be examined through that lens.

Application of Act §4714

[1] At the outset we examine the coverage of these appeals by the new legislation—a matter that was challenged in the appellees' briefs but was not addressed by their counsel during oral argument. As the earlier-quoted Act §4714(c) states, the new amendments apply to any payments by a State for items and services furnished pre-enactment as long as the payment "is the subject of a lawsuit...that is pending as of... the date of the enactment of this Act." In that respect it does not matter whether the congressional labeling of the new legislation as simply a "clarification" has to be credited by a court (a subject that we deal with in a moment). What is instead significant is that Congress' characterization plainly reflects its intention to resolve every still-live dispute in the manner specified by the new legislation. Hence the statutory reference to "pending" lawsuits must be construed as embracing not only undecided cases at the District Court level but also actions pending on appeal, such as the ones before us.

[2] We have previously ascribed precisely that meaning to the term "pending" in *Gray*, 989 F.2d at 1571. There we cited and quoted from numerous earlier decisions upholding Congress' power to impact the results in cases still "pending" on appeal without running afoul of separation of powers principles:

> These cases are properly construed as "pending" cases for separation of powers purposes. *See Griffith*

> *v. Kentucky*, 479 U.S. 314, 321 n.6, 107 S.Ct. 708, 712 n.6, 93 L.Ed.2d 649 (1987)(judgment is "final" and case is no longer pending only after "the availability of appeal [is] exhausted, and the time for a petition for certiorari [has] elapsed or a petition for certiorari finally [has been] denied"); *see also Georgia Ass'n of Retarded Citizens v. McDaniel*, 855 F.2d 805, 813 (11th Cir. 1988)("When it so intends, [Congress'] ability to affect the content of a nonfinal judgment in a civil case, through retroactive legislation ceases only when a case's journey through the courts comes to an end."), *cert. denied*, 490 U.S. 1090, 109 S.Ct. 2431, 104 L.Ed.2d 988 (1989); *de Rodulfa v. United States*, 461 F.2d 1240, 1253 (D.C. Cir.)("[T]he suit is pending until the appeal is disposed of, and until disposition any judgment appealed from it is still *sub judice*.") (internal quotations omitted), *cert. denied*, 409 U.S. 949, 93 S.Ct. 270, 34 L.Ed.2d 220 (1972).

And what *Gray*, *id.* then said, albeit in the different context of a change in a statute of limitations, applies with equal force to give identical content to the word "pending" in Act §4714(c):

> Because none of the cases here have completed their journey through the appellate process, Congress has the authority to change the underlying substantive law by altering the statute of limitations in a way that affects those pending cases.

Because Congress thus has such authority to *change* the law as to pending cases, its power to *clarify* the law—to confirm what the law has always meant—follows a fortiori.

[3] That being the case, the next line of inquiry is whether the new enactment is valid in its application to such pending cases. On that score a key threshold issue is whether the

enactment was truly a "clarification" of the prior statute (as Congress said), or was instead a substantial change in the law. If Act §4714 were to be characterized in the latter fashion, its retroactive application would pose a series of potential constitutional problems. If however Act §4714 merely clarifies what Section 1396a(n) was originally intended to mean, then the Medicaid Act never required states such as California to pay cost-sharing in full. In that event the only function of Act §4714 in this situation is to state more clearly what the law already was—it has no retroactive effect that might be called into constitutional question. Because appellees do not dispute the constitutionality of the prospective application of Act §4714, if that provision merely clarifies Section 1396a(n) there are also no potential constitutional problems with the application of the enactment to these pre-Act cases.

[4] As already indicated, Congress expressly (and formally) stated as its intention that the new provision in Act §4714 was a "clarification" of the payment rules contained in Section 1396a(n). It has been established law since nearly the beginning of the republic (as demonstrated by *Red Lion Broadcasting Co. v. FCC*, 395 U.S. 367, 380-81 & n.8 (1969) and earlier cases cited there) that congressional legislation that thus expresses the intent of an earlier statute must be accorded great weight (see most recently *Loving v. United States*, 116 S. Ct. 1737, 1749 (1996), quoting the *Red Lion* language as earlier repeated in *Consumer Product Safety Comm'n v. GTE Sylvania*, 447 U.S. 102, 118 n.13 (1980); and see also the plurality opinion in *United States v. Winstar Corp.*, 116 U.S. 2432, 2463 (1996)(speaking in terms of "significant weight")).

Other cases that question the competence of a later Congress to opine on the intended meaning of an earlier statute are readily distinguishable. All of those cases have involved attempts to use less formal types of subsequent legislative history, particularly Senate and House Committee Reports, to infer the meaning of prior enactments (*United States v. South-*

western Cable Co., 392 U.S. 157, 170 (1967), rejecting the use of congressional opinions contained solely in House Committee Reports; *Oscar Mayer & Co. v. Evans*, 441 U.S. 750, 758 (1979), rejecting the use of congressional opinions expressed only in Senate Report; and see *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 839-40 (1988), rejecting the use not only of a later House Committee Report but also of the later enactment as such as bases for inferring the intent of an earlier Congress). By contrast, here Congress has formally declared Act §4714 to be a clarification of Section 1396a(n) in the title of the Act as well as in the Committee Reports.[6] Such formal legislative action squarely fits the *Red Lion* mold as so often (and so recently) reconfirmed by later cases, so that Act §4714 is entitled to great weight in construing the meaning of Section 1396a(n).

[5] Appellees contend that Act §4714 effected such a substantial change in federal law in terms of the government's liability to health care providers that it cannot be treated as simply clarifying Section 1396a(n). But that argument proceeds from the premise that Section 1396a(n)'s meaning was clear enough so as to need no further explanation. Not only does that premise ignore the split of authority construing the statute (though to be sure the four Court of Appeals opinions have uniformly rejected Secretary's reading), but even more significantly any quality of crystal clarity is uniformly recognized as totally absent from the Medicaid and Medicare statutes (thus even one of the cases relied on by appellees, *Kozlowski*, 42 F.3d at 1450, has pungently—and accurately—characterized the provisions detailing Medicaid and Medicare

[6]While titles of acts are not part of the law, they can be used to resolve ambiguity in a statute, so long as they do not contradict the actual test (see, e.g., *INS v. National Ctr. for Immigrants' Rights, Inc.*, 502 U.S. 183, 189 (1991) and cases cited there). In this instance the congressional title, rather than merely resolving an ambiguity, parallels the provision in Act §4714(c) that specifically makes the statute applicable to pre-Act services involved in pending litigation.

financing as "among the most completely impenetrable texts within human experience").

[6] Section 1396a(n) is a superb example of the baffling nature of the statute. It has shown itself to be particularly resistant to a single simple interpretation, and hence particularly in need of clarification. While one battle has raged (with mixed results) over whether to accept Secretary's construction of the provision, even the courts that have rejected Secretary's approach have not expressed a single construction of the statute (compare *Kozlowski*, 42 F.3d at 1454, reading Section 1396a(n) to allow a state to exercise the option to pay more for a QMB than for a dual-eligible person; *Perales*, 954 F.2d at 859, stating "it appears that the reason that section a(n) authorizes payment beyond the Medicare amount, when it is required by another section, is to clarify that the Medicaid Act does not prohibit a provider from accepting more than the Medicaid rate"; and *Snider*, 29 F.3d at 895, holding that Section 1396a(n) "authorizes the states to deviate from their schedules or payment methods with respect to QMB Part B cost-sharing payments, thus carving out an exception to the general requirement to comply with the Medicaid fee schedules or payment methods"). Only *Haynes*, 36 F.3d at 1076, by following the interpretation established in *Snider*, avoids the spectre of four Courts of Appeals reaching the same result for four (rather than three) different reasons. Congress noted the existing confusion when it made the statement (really an understatement) that the amount that states were required to pay on behalf of QMBs was "the subject of some controversy" (H. Conf. Rep. No. 105-217, 143 Cong. Rec. H6252 (daily ed. July 29, 1997)).

[7] Given the extraordinary difficulty that the courts have found in divining the intent of the original Congress, a decision by the current Congress to intervene by expressly clarifying the meaning of Section 1396a(n) is worthy of real deference. Appellees' arguments that Act §4714 is new law, despite Congress' unambiguous title for that section, cannot

override that deference, because those arguments incorrectly presume a clearly established meaning for Section 1396a(n)—something that simply did not exist before Act §4714 was adopted.

[8] We therefore honor Congress' "clarification" label and accept Act §4714's provisions as a statement of what Section 1396a(n) has meant all along. That moots all of appellees' constitutional objections to the new legislation, because those objections rest entirely on the assertedly retroactive, rather than declaratory, nature of Act §4714. But it is worth adding that we have, en route to our decision, carefully explored the litigants' arguments both as to the pre-Act version of Section 1396a(n) and as to the constitutional issues raised by appellees if Act §4714 were to be viewed as a retroactive change in, rather than a declaratory clarification of, the prior law—questions implicating the separation of powers, the Contract Clause and the Due Process Clause. And that exploration, which necessitated an effort on our part to parse the intricate and complex provisions of the pre-Act legislation, has only deepened our conviction that Congress' stated intention of clarifying that pre-existing law should be credited.

That leaves only one tag end for discussion, a statutory claim raised by the plaintiff Association in No. 96-55208 ("Beverly") that is unique to it as a provider of inpatient medical services to QMBs under Medicare Part A. Beverly argues in its supplemental brief that Medi-Cal's methodology for reimbursing hospitals for their Medicare expenses under Part A is not legal under either Beverly's or Secretary's interpretation of Act §4714(a)(2). Beverly urges this Court to affirm the district court's ruling below on that ground (under the familiar principle, as repeated in *Herrig v. FDIC*, 82 F.3d 282, 284 (9th Cir. 1996), that an appellate court may uphold a ruling on any basis that the record supports, even if it was not considered by the lower court).

But before an appellate court will consider such an issue, ordinarily the argument must have been raised sufficiently for

the trial court to rule on it (*A-1 Ambulance Serv. v. County of Monterey*, 90 F.3d 333, 338 (9th Cir. 1996), citing *In re E.R. Fegert Inc.*, 887 F.2d 955, 957 (9th Cir. 1989)). In this instance Beverly initially cited a single excerpt from the trial court record that it said had raised the statutory issue about Medi-Cal's Medicare Part A reimbursement policies. But post-argument its counsel has clarified its position as presenting a different assertion: that its current argument could not have been made below because it arose only as a result of standards set forth in the later-enacted Section 4714(a)(1), now codified as Section 1396a(n)(2).

[9] We need not resolve that newly-raised contention, nor does it call for a remand rather than a reversal. Any claim that California is violating the new federal statute—something that is necessarily not encompassed within the scope of the record as it was presented to the trial court and is thus not on review in the appeal before us—really represents the basis for a new lawsuit. Any such claim would call for the generation of a new record, against which a trial court could determine in the first instance whether there is anything to the contention that Act §4714's clarification of the prior law somehow renders the Medi-Cal reimbursement methodology for hospitals under Medicare Part A invalid. And in that respect the trial court would also have to determine whether despite the existence of the new enactment, Beverly's argument on that score is one that it could perhaps have raised the first time around, so that it might be held to have forfeited the argument by virtue of its not having done so in this original litigation.

Conclusion

For the reasons that we have stated here at some length, we conclude that Act §4714 is a clarification of the original intent of Congress when it passed Section 1396a(n). That being the case, the district courts' orders granting summary judgment in favor of each appellee are REVERSED. As a final point, we note that Director Belshe has not requested a remand in order

to seek to recoup any excessive payments made pursuant to the district court's orders. We indicate no view as to her right to obtain any such relief.

APPENDIX B — JUDGMENT OF THE UNITED STATES DISTRICT COURT FOR THE CENTRAL DISTRICT OF CALIFORNIA, WESTERN DIVISION DATED JANUARY 4, 1996

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JUDGMENT ON DECISION BY THE COURT

UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF CALIFORNIA —
WESTERN DIVISION

CASE NO. 95-4053 JSL

BEVERLY COMMUNITY HOSPITAL ASSOCIATION, *et al.*,

Plaintiffs,

v.

S. KIMBERLY BELSHÉ, as Director of the California Department of Health Services,

Defendant.

Appendix B

JUDGMENT

This action came for hearing before the Court on December 11, 1995 with Judge J. Spencer Letts presiding, and the issues having been duly heard and a decision having been duly rendered,

IT IS ORDERED AND ADJUDGED:

1. That summary judgment be granted in favor of plaintiffs on December 11, 1995.

IT IS FURTHER ORDERED THAT, commencing December 11, 1995:

1. Under 42 U.S.C. § 1396a(a)(10)(E)(i), the State of California is obliged to pay the full Medicare cost-sharing amounts on Medicare Part A inpatient hospital services provided to Qualified Medicare Beneficiaries (QMBs), as defined under federal law at 42 U.S.C. § 1396d(p)(1), as it did before May 1, 1994, and as provided in the State Plan amendment approved on June 24, 1994.

2. To the extent that Calif. Welf. & Inst. Code § 14109.5 and Calif. Code of Regs. § 51005(a)(2) can be read to allow the Department to deny cost-sharing for Medicare Part A inpatient hospital services provided to QMBs, they are invalid.

3. Defendant and her successors, officers, agents, servants and employees are permanently enjoined from implementing her policy of denying payment of Medicare cost-sharing amounts, as defined in federal law at 42 U.S.C. § 1396d(p)(3), for inpatient hospital services provided to QMBs.

Appendix B

4. The Order Granting Preliminary Injunction for Plaintiff HIA of California, Inc. (D/B/A Edgemont Hospital), dated October 10, 1995, is made permanent.

5. Defendant and her successors, officers, agents, servants and employees, commencing December 31, 1995, shall begin making full payment of Medicare cost-sharing amounts, as defined in federal law at 42 U.S.C. § 1396d(p)(3), for inpatient hospital services provided to QMBs, as it did before May 1, 1994, and as provided in the State plan amendment approved on June 24, 1994, for all claims not denied as of December 11, 1995.

6. Plaintiffs are the prevailing party; therefore, Defendant shall pay plaintiffs' costs and attorney's fees in this matter, the amount of which shall be provided in future orders.

Dated this 4th day of January, 1996, at Los Angeles, California.

Judge J. Spencer Letts
United States District Court

Presented by:
s/ Michele Melden
Michele Melden, Esq.
HOOPER, LUNDY & BOOKMAN, INC.
Attorneys for Plaintiff
Beverly Community Hospital Association

APPENDIX C — ORDER OF THE UNITED STATES DISTRICT COURT FOR THE CENTRAL DISTRICT OF CALIFORNIA, WESTERN DIVISION, GRANTING SUMMARY JUDGMENT, FILED DECEMBER 18, 1995

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UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF CALIFORNIA,
WESTERN DIVISION

CASE NO. 95-4053 JSL

BEVERLY COMMUNITY HOSPITAL ASSOCIATION, *et. al.*,

Plaintiffs,

v.

S. KIMBERLY BELSHÉ, as Director of the California Department of Health Services

Defendant.

Appendix C

ORDER GRANTING SUMMARY JUDGMENT

Date: Dec. 11, 1995

Time: 3:00 p.m.

Room: Courtroom 4 (Judge Letts)

[stamp] THIS CONSTITUTES NOTICE OF ENTRY AS REQUIRED BY FRCP, RULE 77(d). [stamp]

Having carefully considered Plaintiffs' Motion for Summary Judgment, all Memoranda of Points and Authorities and Exhibits filed in support thereof, Defendant's Opposition, and Parties' arguments on December 11, 1995, THE COURT ORDERED that Summary Judgment be granted in favor of Plaintiffs on December 11, 1995.

IT IS FURTHER ORDERED THAT, commencing December 11, 1995:

1. Under 42 U.S.C. § 1396a(a) (10) (E) (i), the State of California is obliged to pay the full Medicare cost-sharing amounts on Medicare Part A inpatient hospital services provided to Qualified Medicare Beneficiaries (QMBs), as defined under federal law at 42 U.S.C. § 1396d(p)(1), as it did before May 1, 1994, and as provided in the State Plan amendment approved on June 24, 1994.

2. To the extent that Calif. Welf. & Inst. Code § 14109.5 and Calif. Code of Regs. § 51005(a) (2) can be read to allow the Department to deny cost-sharing for Medicare Part A inpatient hospital services provided to QMBs, they are invalid.

3. Defendant and her successors, officers, agents, servants and employees are permanently enjoined from implementing her policy of denying payment of Medicare cost-sharing amounts, as defined in federal law at 42 U.S.C. § 1396d(p) (3), for inpatient hospital services provided to QMBs.

4. The Order Granting Preliminary Injunction for Plaintiff HIA of California, Inc. (D/B/A Edgemont Hospital), dated October 10, 1995, is made permanent.

5. Defendant and her successors, officers, agents, servants and employees, commencing December 31, 1995, shall begin making full payment of Medicare cost-sharing amounts, as defined in federal law at 42 U.S.C. § 1396d(p) (3), for inpatient hospital services provided to QMBs, as it did before May 1, 1994, and as provided in the State Plan amendment approved on June 24, 1994, for all claims not denied as of December 11, 1995.

6. Plaintiffs are the prevailing party; therefore, Defendant shall pay plaintiffs' costs and attorney's fees in this matter, the amount of which shall be provided in future orders.

Dated: December 18, 1995

s/ J. Spencer Letts
Judge J. Spencer Letts
United States District Court

Presented by:

John R. Hellow, Esq.
COOPER, LUNDY & BOOKMAN, INC.
Attorneys for Plaintiff
Beverly Community Hospital Association

APPENDIX D — ORDER OF THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT FILED MARCH 3, 1998

NOT FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

NO. 96-55208

D.C. NO. CV-95-4053 JSL

BEVERLY COMMUNITY HOSPITAL ASS'N

Plaintiff-Appellee,

v.

S. KIMBERLY BELSHE, Director of the California Dep't of Human Services,

Defendant-Appellant.

Nos. 96-56249
96-56485
96-56648
97-55022

D.C. Nos. CV-96-2322-JSL
CV-96-3033-JSL

Appendix D

CALIFORNIA AMBULANCE ASS'N,
CALIFORNIA MEDICAL ASS'N, *et al.*

Plaintiffs-Appellees,

v.

S. KIMBERLY BELSHE, Director of the California Department of Human Services, and DONNA E. SHALALA, Secretary, United States Dep't of Health and Human Services

Defendants-Appellants.

Nos. 96-56699
96-56745
96-55713
97-55220

D.C. Nos. CV-96-5564-JSL

RICHARD GILMORE, *et al.*,

Plaintiffs-Appellees,

v.

S. KIMBERLY BELSHE, Director of the California Dep't of Human Services, and DONNA E. SHALALA, Secretary, United States Dep't of Health and Human Services

Defendants-Appellants.

Appendix D

ORDER

Before: REINHARDT and TASHIMA, Circuit Judges, and SHADUR, District Judge.**

The panel has voted to deny the petitions for rehearing and to reject the suggestions for rehearing en banc. The full court has been advised of the suggestion for rehearing en banc, and no judge of the court has requested a vote on the suggestions for rehearing en banc. Fed. R. App. P. 35(b)

The petitions for rehearing are denied and the suggestions for rehearing en banc are rejected.

** The Honorable Milton I. Shadur, Senior United States District Judge for the Northern District of Illinois, sitting by designation.

APPENDIX E — STATUTES AND CONSTITUTIONAL PROVISIONS INVOLVED

42 U.S.C. § 1369(a)(10)(E)(i)

§ 1396a. State plans for medical assistance

(a) Contents

A State plan for medical assistance must —

* * *

(10) provide —

* * *

(E)(i) for making medical assistance available for medicare cost-sharing (as defined in section 1396d(p)(3) of this title) for qualified medicare beneficiaries described in section 1396d(p)(1) of this title;

* * *

42 U.S.C. § 1369a(n)

(n) Payment amounts

(1) In the case of medical assistance furnished under this subchapter for medicare cost-sharing respecting the furnishing of a service or item to a qualified medicare beneficiary, the State plan may provide payment in an amount with respect to the service or item that results in the sum of such payment amount and any amount of payment made under subchapter XVIII of this chapter with respect to the service or item exceeding the amount that is otherwise payable under the State plan for the item or service for eligible individuals who are not qualified medicare beneficiaries.

(2) In carrying out paragraph (1), a State is not required to provide any payment for any expenses incurred relating to payment for deductibles, coinsurance, or copayments for medicare cost-sharing to the extent that payment under subchapter XVIII of this chapter for the service would exceed the payment amount that otherwise would be made under the State plan under this subchapter for such service if provided to an eligible recipient other than a medicare beneficiary.

(3) In the case in which a State's payment for medicare cost-sharing for a qualified medicare beneficiary with respect to an item or service is reduced or eliminated through the application of paragraph (2) —

> (A) for purposes of applying any limitation under subchapter XVIII of this chapter on the amount that the beneficiary may be billed or charged for the service, the amount of payment made under subchapter XVIII of this chapter plus the amount of payment (if any) under the State plan shall be considered to be payment in full for the service;
>
> (B) the beneficiary shall not have any legal liability to make payment to a provider or to an organization described in section 1396b(m)(1)(A) of this title for the service; and
>
> (C) any lawful sanction that may be imposed upon a provider or such an organization for excess charges under this subchapter or subchapter XVIII of this chapter shall apply to the imposition of any charge imposed upon the individual in such case.

This paragraph shall not be construed as preventing payment of any medicare cost-sharing by a medicare supplemental policy or an employer retiree health plan on behalf of an individual.

Appendix E

* * *

42 U.S.C. § 1396(d)(p)(3)

* * *

(3) The term "medicare cost-sharing means (subject to section 1396a(n)(2) of this title) the following costs incurred with respect to a qualified medicare beneficiary, without regard to whether the costs incurred were for items and services for which medical assistance is otherwise available under the plan:

(A)(i) premiums under section 1359i-2 or 1395i-2a of this title, and

(ii) premiums under section 1395r of this title.

(B) Coinsurance under subchapter XVIII of this chapter (including coinsurance described in section 1395e of this title).

(C) Deductibles established under subchapter XVIII of this chapter (including those described in section 1395e and section 1395(b) of this title).

Such term also may include, at the option of a State, premiums for enrollment of a qualified medicare beneficiary with an eligible organization under section 1395mm of this title.

* * *

Appendix E

BALANCED BUDGET ACT OF 1997, PUB. L. 105-33 § 4714, 111 STAT. 251, 509-10

SEC. 4714. MEDICAID PAYMENT RATES FOR CERTAIN MEDICARE COST-SHARING.

(a) CLARIFICATION REGARDING STATE LIABILITY FOR MEDICARE COST-SHARING. —

(1) IN GENERAL. — Section 1902(n) (42 U.S.C. 1396a(n)) is amended —

(A) by inserting "(1)" after "(n)", and

(B) by adding at the end the following:

"(2) In carrying out paragraph (1), a State is not required to provide any payment for any expenses incurred relating to payment for deductibles, coinsurance, or copayments for medicare cost-sharing to the extent that payment under title XVIII for the service would exceed the payment amount that otherwise would be made under the State plan under this title for such service if provided to an eligible recipient other than a medicare beneficiary.

"(3) In the case in which a State's payment for medicare cost-sharing for a qualified medicare beneficiary with respect to an item or service is reduced or eliminated through the application of paragraph (2) —

"(A) for purposes of applying any limitation under title XVIII on the amount that the beneficiary may be billed or charged for the service the amount of payment made under

title XVIII plus the amount of payment (if any) under the State plan shall be considered to be payment in full for the service;

"(B) the beneficiary shall not have any legal liability to make payment to a provider or to an organization described in section 1903(m)(1)(A) for the service; and

"(C) any lawful sanction that may be imposed upon a provider or such an organization for excess charges under this title or title XVIII shall apply to the imposition of any charge imposed upon the individual in such case.

This paragraph shall not be construed as preventing payment of any medicare cost-sharing by a medicare supplemental policy or an employer retiree health plan on behalf of an individual.".

(2) CONFORMING CLARIFICATION. — Section 1905(p)(3) (42 U.S.C. 1396(p)(3)) is amended by inserting "(subject to section 1902(n)(2))" after "means".

(b) LIMITATION ON MEDICARE PROVIDERS. —

(1) PROVIDER AGREEMENTS. — Section 1866(a)(1)(A) (42 U.S.C. 1395cc(a)(1)(A)) is amended —

(A) by inserting "(i)" after "(A)", and

(B) by inserting before the comma at the end the following: ", and (ii) not to impose any charge that is prohibited under section 1902(n)(3)".

Appendix E

(2) NONPARTICIPATING PROVIDERS. — Section 1848(g)(3)(A) (42 U.S.C. 1395w-4(g)(3)(A)) is amended by inserting before the period at the end the following: "and the provisions of section 1902(n)(3)(A) apply to further limit permissible charges under this section".

(c) EFFECTIVE DATE. — The amendments made by this section shall apply to payment for (and with respect to provider agreements with respect to) items and services furnished on or after the date of the enactment of this Act. The amendments made by subsection (a) shall also apply to payment by a State for items and services furnished before such date if such payment is the subject of a law suit that is based on the provisions of section 1902(n) and 1905(p) of the Social Security Act and that is pending as of, or is initiated after, the date of the enactment of this Act.

Appendix E

UNITED STATES CONSTITUTION, AMENDMENT V

* * * nor shall private property be taken for public use, without just compensation.

UNITED STATES CONSTITUTION, ARTICLE III

SECTION 1. The judicial Power of the United States, shall be vested in one supreme Court, and in such inferior Courts as the Congress may from time to time ordain and establish. The Judges, both of the supreme and inferior Courts, shall hold their Offices during good Behaviour, and shall, at stated Times, receive for their Services, a Compensation, which shall not be diminished during their Continuance in Office.

SECTION 2. The judicial Power shall extend to all Cases, in Law and Equity, arising under this Constitution, the Laws of the United States, and Treaties made, or which shall be made, under their Authority; — to all Cases affecting Ambassadors, other public Ministers and Consuls; — to all Cases of admiralty and maritime Jurisdiction; — to Controversies to which the United States shall be a Party; — to Controversies between two or more States; — between a State and Citizens of another State; — between Citizens of different States; — between Citizens of the same State claiming Lands under Grants of different States, and between a State, or the Citizens thereof, and foreign States, Citizens or Subjects.

In all Cases affecting Ambassadors, other public Ministers and Consuls, and those in which a State shall be Party, the Supreme Court shall have original Jurisdiction. In all the other

Appendix E

Cases before mentioned, the supreme Court shall have appellate Jurisdiction, both as to Law and Fact, with such Exceptions, and under such Regulations as the Congress shall make.

The Trial of all Crimes, except in Cases of Impeachment, shall be by Jury; and such Trial shall be held in the State where the said Crimes shall have been committed; but when not committed within any State, the Trial shall be at such Place or Places as the Congress may by Law have directed.

SECTION 3. Treason against the United States, shall consist only in levying War against them, or in adhering to their Enemies, giving them Aid and Comfort. No Person shall be convicted of Treason unless on the Testimony of two Witnesses to the same overt Act, or on Confession in open Court.

The Congress shall have Power to declare the Punishment of Treason, but no Attainder of Treason shall work Corruption of Blood, or Forfeiture except during the Life of the Person attainted.

APPENDIX F — EXHIBIT TO SUPPLEMENTAL BRIEF TO UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT BY APPELLEES CALIFORNIA AMBULANCE ASS'N AND CALIFORNIA MEDICAL ASS'N ET AL.

CONGRESSIONAL BUDGET OFFICE
U.S. CONGRESS
WASHINGTON, D.C. 20515

June E. O'Neill
Director

August 12, 1997

Honorable Franklin D. Raines
Director
Office of Management and Budget
Washington, D.C. 20503

Dear Mr. Raines:

The Congressional Budget Office, after consulting with the Committees on the Budget of the House of Representatives and the Senate, provides the enclosed estimates of the effects of H.R. 2014 (Public Law 105-34), the Taxpayer Relief Act of 1997, and H.R. 2015 (Public Law 105-33), the Balanced Budget Act of 1997, on direct spending and receipts. These estimates are required by section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985. H.R. 2014 and H.R. 2015 were cleared by the Congress on July 31 and signed by the President on August 5. Section 10213 of H.R. 2015 provides that these two laws are not counted for pay-as-you-go purposes.

On August 11 the President identified on provision of Public Law 105-33 and two provisions of Public Law 105-34 for cancellation under the terms of the Line Item Veto Act. CBO's estimates do not reflect the effects of the proposed cancellations.

Appendix F

Sincerely,

s/ June E. O'Neill
June E. O'Neill

Enclosures

Appendix F

BUDGETARY IMPLICATIONS OF THE BALANCED BUDGET ACT OF 1997

SUMMARY AND INTRODUCTION

As part of a plan to balance the federal budged by 2002, the 105th Congress enacted and President Clinton signed two major pieces of legislation: The Taxpayer Relief Act of 1997 (H.R. 2014/ Public Law 105-34) and the Balanced Budget Act of 1997 (H.R. 2015/Public Law 105-33). The Balanced Budget Act achieves $127 billion in net deficit reduction over the 1998-2002 period. Gross savings of $160 billion comprise:

- $112 billion from slowing the growth of the Medicare program;
- $21 billion from auctioning licenses to use portions of the electromagnetic spectrum;
- $7 billion from changes to Medicaid;
- $15 billion from other spending reductions and tax increases.

These savings are partly offset by additional spending of $33 billion:

- $20 billion for children's health insurance initiatives and
- $13 billion to mitigate the effects of last year's welfare reform law.

The act also extends the limits on discretionary spending and the pay-as-you-go procedures for direct spending and receipts, but these provisions do not directly alter federal outlays or revenues. The summary table provides estimates of the act's budgetary effects by title. The following pages give details by program and provisions.

* * *

percent of costs in 2002, and 70 percent of costs in 2003. By 2003, CBO estimates that states will maintain reimbursement rates to FQHCs and rural health centers at a level consistent with overall Medicaid payment rates. This provision will reduce Medicaid costs by $0.3 billion over the next five years, compared with prior law.

Medicaid Rates as Payment in Full. In recent years, many states have been required by court decisions to pay full Medicare rates for cost sharing for QMBs and people dually eligible for Medicare and Medicaid. This provision overturns these decisions and gives states the option not to pay providers Medicare cost sharing amounts in excess of Medicaid rates. According to the Physician Payment Review Commission, Medicaid payments rates are on average about 73 percent of Medicare payment rates. Limiting payment rates to providers for QMBs and dual eligibles to the lower payment rates will generate about $5 billion in federal Medicaid savings. However, CBO assumes that about one-third of the combined federal and state savings will be offset by behavioral responses by providers in the Medicare program, increasing Medicare costs by about $2.9 billion. The net federal savings in the two programs will be about $2.1 billion.

* * *

Appendix F

Treatment of Veterans' Pensions Under Medicaid. Under prior law, payments by the Department of Veterans Affairs for aid and attendance were not counted toward income for veterans in state veterans homes. This provision will count these payments as income, thus reducing Medicaid's contribution to the cost of veterans' institutional care. CBO estimates that this provision will reduce Medicaid outlays by $0.1 billion over five years.

Federal Payments to States. This provision specifies allotments that will limit the amount of federal reimbursement available for state disproportionate share hospital (DSH) programs, waives certain provider tax provisions for New York, provides funding for health services furnished to undocumented aliens, provides new tools to combat fraud and abuse, increases the federal medical assistance percentage (FMAP) for Alaska and the District of Columbia, and increases payment limits for the territories.

Limits on Disproportionate Share Hospital (DSH) Payments. The provision establishes specific state allotments for DSH payments for each year in the 1998-2002 period. For 2003 and later years, allotments will equal the lower of the previous year's allotment increased by the Consumer Price Index for medical services for the previous fiscal year or 12 percent of a state's medical assistance expenditures. The provision also limits state DSH expenditures for institutions for mental diseases (IMDs) in 1998 through 2000 to the lesser of the amount spent on those institutions in 1995 or the percent of DSH spending on those institutions in 1995 applied to the 1998-2000 allotments. The amount of DSH spending for mental health will be held to 50 percent of DSH spending in 2001, 40 percent of DSH spending in 2002, and 33 percent of DSH spending in succeeding fiscal years. CBO estimates that these limitations will prevent some states from spending up their allotments. On

* * *

Table 4D.--Estimated Budgetary Impact of Subtitle H, Medicaid

(By fiscal year, in billions of dollars)	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	1998-2002 Total	1998-2007 Total
Chapter 1 - Managed Care												
Application of standards for emergency conditions	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.3
Chapter 2 - Flexibility in Payment of Providers												
Repeal of Boren requirements	0.0	-0.1	-0.2	-0.4	-0.5	-0.7	-0.9	-1.1	-1.4	-1.8	-1.2	-8.9
FQHC payment reform	-0.0	-0.0	-0.0	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-1.3
Medicaid rates for Medicare cost sharing for QMB and dually eligible beneficiaries												
Medicaid	-0.8	-0.9	-1.0	-1.1	-1.2	-1.3	-1.4	-1.5	-1.7	-1.8	-5.0	-12.~
Medicare Benefits	0.5	0.5	0.6	0.6	0.7	0.7	0.8	0.9	1.0	1.0	2.9	7.3
Treatment of Veteran's Pensions	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.1	-0.2
Chapter 3 - Federal Payments to States												
Reforming DSH payments /a	-0.1	-1.0	-2.1	-3.2	-4.1	-4.8	-5.2	-5.9	-6.7	-7.8	-10.4	-40.4
Treatment of state taxes	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.2
Additional funding of emergency health services for illegal aliens	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
Elimination of waste fraud and abuse /b	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0
Increased FMAPs for Alaska and DC	0.2	0.2	0.3	0.2	0.2	0.2	0.2	0.3	0.3	0.3	1.1	2.5
Increase payment limits for the territories	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.4
Chapter 4 - Eligibility												
Option for 12 month continuous eligibility	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.7	1.8
Payment of Medicare Part B premium assistance - Medicare Spending	0.2	0.3	0.3	0.4	0.4	0.0	0.0	0.0	0.0	0.0	1.5	1.5
State option to buy in disabled workers /b	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Chapter 6 - Administration and Miscellaneous												
Extension of moratorium for certain IMDs /b	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Subtitle H, Total Change in Medicaid	-0.4	-1.8	-2.9	-4.3	-5.5	-6.3	-7.2	-8.3	-9.4	-10.7	-14.8	-58.4
Subtitle H, Total Change in Medicare	0.7	0.8	0.9	1.0	1.1	0.7	0.8	0.9	1.0	1.0	4.4	8.8

SOURCE: Congressional Budget Office

NOTE: Components may not sum to totals because of rounding.

a. Estimate includes interaction with Children's Health Insurance Programs and other welfare programs.
b. Less than $50 million over the 1998-2002 period.

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